Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-07550 State of Maryland / Department of Health and Mental Hygiene Israel Leonides Aziles-Auceda 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 8, 2011 2232 hrs **Medical Examiner** Israel Leonidas Aviles-Auceda c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Essex Stumpf Road @ Ebenezer Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours country) Honduras 04/23/1956 Director 1X M 2 F 55 None Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Harford Edgewood 28a-f show death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Honduras 21040 1728 Judy Way items 23a or Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes 5 imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

act: If item 27 is marked other than "natural", or other traumaife even; the Medical Examiner. Specify: Hispanic 1 ★ Yes 2 No specify: Honduras 3 Widowed 4 Divorced If Yes, Give Yee ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Landscape Labor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilaria Auceda Nicolas Arnold Aviles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 Judy Way, Edgewood, Md. 21040 Alan Auceda/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from or other permit. Pages Department o Important: 10/20/11 Honduras al Cemetery 4 Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th. St. NE Washington D.C. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Wedica Death Multiple Injuries Immediate Cause (Final disease а kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and or use as the burial - transi an/Medical X AMENDED Item 1 as noted per me, g922 12-8-11 sm UNPENDED Records. P.O. Box 68760. 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnency Year Live birth Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Physici 1 Yes 2 No 9 Unknown cate has been signed by the att page 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of eutopsy performed? death? 2 No Yes 2 No ✓ Yes the Hospital nr Attending Physician: Thin 24 hours after death.

the Funeral Director: After this certific inpletely filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital å examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes ၉ 28a. Date of Injury (Month Day Year) Oct 8, 2011 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Passenger auto fixed object collision 1 Natural 2226 hrs 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Stumpf Road @ Ebenezer Road, Essex, MD To the Hospital of within 24 hours at To the Funeral I determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸

29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registra

Registrar's Sign

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 9, 2011

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 1<sup>pt</sup>, 201°f 23:58 Alemei Yenesew Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince Georges Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** 0470211933 Ethiopia 78 unknown 1**X** M 2 □ F **Director** Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 □ No Washington none 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 20009 Ethiopia 3023 14th Street, N.W. Apt. 107 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, et 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha Engineer Office Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Abunei Alemei Gobezay Etagengen Afwork 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Anteneh Abunei (Son) 628 Cannon Road Silver Spring, Md. 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date cemetery, crematory or other promiting Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/20/2011 Addis Ababa, Ethiopia Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. acute Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Qertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 10 0055120

Registrar

DHMH 17 Rev 06-2011

State

1328 Jonkem anna SE Sute 310 Washington De 20032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Richard Yalmer

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 18, 2011 10:37 Charles Mason Allender Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Talbot Easton Easton Memorial Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours November 6. Marvland 1936 Director 217-30-3206 74 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and the medical examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No Caroline Denton Maryland| 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21629 9993 Tuckahoe Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 If Yes, Give Completed by 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Parts Business Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Edna Rebecca Clopper Charles Fike Allender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9993 Tuckahoe Road Denton, Maryland Kathleen Allender/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dover, Delaware Capitol Crematory 10/20/2011 Moore Funeral Home, P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Denton, Maryland 21629 12 South Second Street 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ TERY CORONARY CON disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed to the second 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate ha irector, page 2 perform 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 🗌 Yes 1 Inpatient ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury 28b, Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) injury work?
1 Yes 2 No 5 Pending hours after death. neral Director: Aff I filled in by the fur Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Configure Practice To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D 6653815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Korah Pulimood, M.D.

31. Date filed (Month, Day, Year)

912 Market Street

32. Registrar's Signature

21629

Denton, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct 15 2011ay 6:46 P Lois Hunter Judge Boesch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death c. County of Death **Calvert** Asbury Solomons Health Care Center Solomons 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days 220-38-2959 Months Hours Ma**l<sup>e</sup>cti<sup>n</sup>, 22<sup>y,</sup> 191**6 Marvii ind Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at filed within 72 hours after death with the Maryland Oc. City, Town or Location Solomons 10d. Inside City Limits Director Maryland Calvert 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11450 Asbury Circle 20688 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify Specify: "natural" 3 XWidowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) trainer retail sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever and Mental I မ Albert Fricke Judge Eva Hunter Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn King - daughter 940 Ellendale Dr. Towson MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of October 174, 2011 Metropolitan Funeral Service 20c. Location - City or Town, State 1 D Burial 2 Coremation 3 D Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee Dinous 4405 Broomes Is. Rd. Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Chysician/ COMPLICATIONS FARI Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 1 ☐ Yes 2 ☐ Unknown the g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate 2 🗸 Yes 24 hours after deaun.

• Funeral Director. After this certifice listed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Natural iniury 5 Pending ☐ Accident Investigation 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name an ddress of person who completed cause of death (Item 23a) (Type, Print) INCE FREDERICE MY-20678 32. Registr 31. Date filed (Month, Day, State Registrar

	Physici /Medic Examin	al	1.D
	Funeral Director		5. S
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, I'm Medical Evan national be natified at once.	To Be Completed by Funeral Director	4a. C a c c c c c c c c c c c c c c c c c c

Physician /Medical Examiner

To the Hospital or Attending Physician: he law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certific te has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	State of Maryland / Department of Health and Mer  1 - State Registrar Certificate of Death	ntal Hygiene 2011 34505
ian	1. Decedent's Name (First, Middle, Last)  2.	Date of Death Month ct. 10, Day 2011 3. Time of Death 1425 M
cal ner	4a. Facility Name (If not institution, give street and number)  Calvert Memorial Hospital  4b. City, Town, or Location of Death Prince Frederic	4c. County of Death
Г	5. Social Security Number 212-24-2669  6. Sex 1	Date of Birth (Month, Day, Year)  ug. 24, 1926  9. Birthplace (State or Foreign Country)  MD
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
ector	MD Calvert Huntingtown	1 ☐ Yes 2 🖾 No
al Dìr	10e. Street and Number 6451 Huntingtown Road 10f. Zip Code 20639	USA
Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No  If Yes, Give  Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify fixes, specify Cuban, Mexican, Puerto Ric  1 □ Yes 2 ▼ No  1 □ Yes 2 □ No Specify:	y Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc. Specify: Black
npletec	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  Farmer	Farming
e Cor	5 Tarmer	irst, Middle, Maiden Surname)
To B		
	19a. Informant's Name/Relationship (Type. Print)  Gail Booze/daughter  19b. Mailing Address (Street and Number or Rural R 6485 Huntingtown Rd.	Huntingtown, MD 20639
	4 □ Donation 5 □ Other (Specify)	2011 Sunderland, MD
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewe 1451 Dares Beach Prince Frederick.	11 Funeral Home, P.A. Rd MD 20678
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	
П	Immediate Cause (Final disease or condition resulting in death)  a. End 5 tage 8 curd    Due to (or as a consequence of):  Heart	lisean
<u>.</u>		Failure
amjue	cause. Enter Underlying Cause (Disease or injury that initiated events  C	nbosis
edical Examiner	resulting in death) Last  Due to (or as a consequence of):  De Menting	
	IF FEMALE:	
hysician/	23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery  Month Day Year
l by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
Completed by Physician/M		24a. Was an autopsy performed?  1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Be C	25. Was case referred to medical examiner?  Hospital: Hospital: Other: Other:	Check only one)
n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c.	5 ☐ Residence 6 ☐ Other (Specify)  d. Describe how injury occurred
cation	2 Accident investigation M 1 Yes 2 No	
Sertifi	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	. Location (Street and Number or Rural Route Number, City or Town, State)
Medical Certification; To	29a. Certifier  (Check only one)  1 ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
Me	29b. Signature and title of certifier  D 50290	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dhirey SWC 130 HOSP RD Prince	Fred MD 20678
ate rar	31. Date filed (Month, Day, Year)  OCT 13 2011  A Angel	

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last)
Lucy Lucille Buckmaster Day 2011 October 10, 0725 A **Physician** 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert Examiner Prince Frederick Calvert Memorial Hospital 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1938 | Months | Days | Hours | Min. | June 16 5. Social Security Number Mary Tand **Funeral** 1 □ M 2 🖸 F 219-88-6222 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination in with the natified at once. 10b. County 10a. State Hughesville 1 ☐ Yes 2X No Charles Maryland Director 10g. Citizen of What Country?
United States 10f, Zip Code 10e. Street and Number 20637 17710 Prince Frederick Rd 14. Race - American Indian, Black, White, etc. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ŪNo If Yes, Give Year or Dates: 11 Marital Status white 1 Never Married 2 Married Specify 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) n/a Elementary/Secondary (0-12) College (1-4or 5+) never worked n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Edna Gibson Be William McCullen Buckmaster ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Augustus Dr. Prince Frederick MD 20078 19a. Informant's Name/Relationship (Type. Print) Anne V. Hutchins - sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of ASDULY Cemeter, Commander or other place) Barstow Maryland 20a. Method of Disposition Oct 14 2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 BKausa Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUKEMIA Physician Due to (or as a consequence of): /Medical TARDATION Examiner MENTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death Year 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? this certificate has been signed by al director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Introduction ≥ 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 ☐Yes 2 ☑No 1 Yes 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After the funeral 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hospital 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RW Sidhu 100 Hospital 2 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34507 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ BALDONI CHRISTOPHER 10:46, PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 25, 1 X M 2 D F Hours 327-44-7339 60 Yrs **Director** 1951 Illinois Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 351 South Woodyear Street 21223 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exar 3 Widowed 4 X Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Computer Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Consulting permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jules Baldoni Violet Nell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 Crums Church Road, Berryville, Virginia 22611 Matthew Baldoni/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Enders & Shirley
Fineral Home & Crematory Oct. 14,2011 Berryville, Virginia 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Junera 22. Name and Address of Facility Hilton Funeral Home 22111 Beallsville Rd. Barnesville, MD 20838 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pulmonum ea Ph sician/ disease or condition resulting in death) Edem 9 Medical Examiner 7 days Cardina arm tumin Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sleep Apnew, Obesity, hyperlipidenia Company heart disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Type I Diabetes Hyperteniion 24a. Was an Hospital or Attending Physician; The law nas e 2 r this certificate has aral director, page 2 autopsy performed? 1 ☐ Yes 2 ☑ No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No 1 🗌 Yes 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No injury ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) ပ 29c. License numbe MD RES001 October 10,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARUN GANESH 3001

State Registrar 31. Date filed (Month)

Hunover Street

South

32. Registrar's Signature

Baltimo-c, MD, 21225

11-07721 Anisa Blizzard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

nisa Blizzard	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  2011 34508							
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year							
nedical Examine	Anissa Lynn Blizzard  4a. Facility Name (if not institution, give street and number)  Easton Memorial Hospital  October 15, 2011  4c. County of Death Talbot							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 M 2 F 42 Yrs.  7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 Months							
Varyland 28a-f show any d at once. rector	Usual Residence of Decedent  10a. State							
r death with the l or items 23a or must be notifie Funeral Dil	10f. Zip Code  10f. Zip Code  10f. Zip Code  10g. Citizen of What Country?  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1							
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", or event, the Medical Examiner To Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Waterwomen Seafood  17. Father's Name (First, Middle, Last)  Seafood							
MD 21215 d 2 should be file lith and Mental H n 27 is marked o n 27 is marked To Be To Be	Wilbur Kenneth Hutson Shirley Lucille Baynard							
Baltimore, MD 21215-( permit. Pages I and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the To Be Cc	20a. Method of Disposition  20a. Method of Disposition (Name of cemetery, crematory or other place)  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fairview Church Cemetery 10/20/2011 Cordova, Maryland  22. Name and Address of Facility Moore Funeral Home, P.A.  12 South Second Street Denton, Maryland 21629							
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Atherosclematic Cardiovascular Disease							
be executed sician and untal - transit addical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.							
	UNPENDED  AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown  23d. Date of delivery Month Day Year							
Cords, P.O. law requires that the has been signed by 2 should be detach mpleted by P	1 Yes 2 No 3 Probably 4 ✓ Unknown							
ion of Vital Re- tending Physician: The eath. After this certificate the funeral director, page ation: To Be Cor	25. Was case referred to medical examiner?  1  Yes 2 No  28. Date of Injury 28. Injury at Work?							
Divis Bapital or At hours after of filled in by Certific	The state of the s							
To the HG within 24 To the Fu Completely completely	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29b. Signature and title of certifier  29c. License number  O.C.M.E.  October 16, 2011							
State	30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Month Personal 32. Registrar's Signature)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:38 Brown Joann Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death University of Maryland Medical Center Baltimore Baltimore City 6. Sex If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Year 19<u>47</u> Hours Min. 1 - M 2 XF VA 64 Director 247-82-9754 28a-f show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 201 Beethoven Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates "natural", Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) the own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o Department of Health and Menta Important: If item 27 is marked any injury or other the once 2 James Lewis Matthews II Jolene Rae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD Christopher Brown/Husband Beethoven Dr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State Carroll Cremation Ind 10/24/2011 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licen 22. Name and Address of Factoritts Funeral Home & Chapel, PA K 412 Washington Rd. Westminster, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Muelodysplastic Sundrome disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, -transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Por Year Month Day Pregnant at time of death detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed' death? eral Director: After this certificate I filled in by the funeral director, pag 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No <u>م</u>| 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? within 24 hours after death To the Funeral Director: A Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) otherme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Schrenk South Greene Street Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

OCT 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Buser 20 Chester Herbert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WMHS-RMC Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth **Funeral** 1 XM 2 □ F Months Hours Min. *™ec°*5,<sup>∨</sup>1936 232-62-6286 74 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director WV Mineral Ridgeley 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 26753 USA Rt.1 Box 495 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Korea white permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Xerox Corp. Technical Representative Be 18. Mother's Name (First, Middle, Maiden Surname)

Margaret McNeil 17. Father's Name (First, Middle, Last) ည Chester Buser 19a. Informant's Name/Relationship (Type, Print) Nancy Buser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26753 Rt. 1 Box 495 wife 20c. Location - City or Town, State 20a. Method of Disposition
1 Durial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of MD Hillcrest Memorial Park Cumberland Donation 5 Other (Specify) f-Funeral Ser 22. Name ans carpein Fulferal Home, PA vice Aicensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Box in the past 12 months?
1 Yes 2 No Month Day Year the detached P.O. signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? 2 No certificate Yes 2 No Division of Vital completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Yea 29b. Signature a 29c. License number 30. Name and address of person who completed sause death (Item 23a) (Type, Print) Jr. M.D. 200 Glenn St. Ste. 302 Cumberland, My 21502

Registrar

State

OCT 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🥎 3. Time 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 23°. 20 II 0610 Evelyn Marie Barber М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll 322 Church Ct. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug 21, Year) 918 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Days Min. 1 M 2X F Hours Country) Director 220-03-2214 93 PA Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral hours after death with 322 Church Ct. 21157 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any Injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Clarence Staup Margaret Gertrude Etzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Barber/Daughter 3001 Gillis Falls Rd. Mt. Airy, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/25/2011 4 Donation 5 Other (Specify) Evergreen Memorial Finksburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ritts Funeral Home & Chapel, PA V-Y 412 Washington Rd. Westminster, MD 23a. Pax. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Emphysema disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of ohysician and the burial-transit executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death ed by the a 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? P 1 🗌 Yes Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this funeral 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 D17040 October 24, N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 215 Washington Heights Medical Center M.D. Howard G. Lanham, Westminster, MD 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 28 2011 parke Registrar

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F			giene leg. No. 2011	34512
	Physici		1. Decedent's Name (First, Middle)					2. Date of Dea Month Octobel	Day Year	3. Time of Death 6:15 P
è	/Media Examir		Genevieve I  4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Dea		4c. County of Deat	
	Zami		Somerford Place	ce		Colu	mbia		Howard	
	Funeral Director		5. Social Security Number 218–26–2903	1 □ M 2 1 3 F	(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hr: Hours Min			hplace (State or Foreign ountry) yland
	D		Usual Residence of Decedent					Aug 20	, 1930 Mai	-
	death with the Maryland oms 23s or 28e-f show f must by radified at	5	MD 10b. County	_	10c. City, Town or Lo E.11i	cott Cit	v			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28e-	Director	10e. Street and Number			10f. Zip Code	<u> </u>		log. Citizen of What Co	ountry?
	h witl		10215 Raleigh	Tavern Lane		2104	42		United St	ates
	ems :	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.			Specify Yes or No- rto Rican, etc.)		nicen Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28e-f show or other treumatic event, the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		)	1□Yes 2√2No	Specify:	,,	Specify:	
21215-0036	2 hou		15. Decedent	s Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/	ite Industry
21	within 7 ene. then "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+	life.	kind of work done on DO NOT use retired	during most or wi	orking		
	filed v Hygie other t		12 17. Father's Name (First, Middle, L	acti	Admir	istrative		ant me (First, Middle,	Paint Comp	any
Maryland	id be f ental i ked of	To Be		Napoli				phine La		
ary	2 should be and Mental is marked eumatic ev	-	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street		4	r, City or Town, State, 2	Zip Code)
-	and 2 salth a n 27 ls		Patricia A. Cira	asole/daughte	er 10215	Raleigh	Tavern	Lane Ell	Licott City	, MD 21042
Baltimore	permit. Pages 1 an Department of Heal Importent: if Item 2 any injury or other once.		20a. Method of Disposition Burial 2 Cremation	3 □Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	(e)	Date	20c. Location - City or	Town, State
Ħ.	it. Pa rtmen rtent: nlury		' 4 ☐ Donation 5 ☐ Other (Sp 21. Signatife) of Funeral Service L	ecify)	Dulaney V	alley Mer	n Gar. 1	0/18/11	Cimonium, M	aryland
Ba	permit. Departr Importe any ince.		Juanuta (R	Homes					icott City,	ily F.H. In MD 21043
٠	Physician /Medical Examiner	ner	23a. Part1 (Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	inty one cause on early line	norme					Approximate Interval Between Onset and Death YEARS  YEARS
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d	consequence of):	<b>u</b>			Syears	
P.O. Box	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/Me	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
-	w requires that been signed I should be det	by	Part II. Other significant condition	rescontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to es 2□No 3	the cause of death?
							utopsy findings available completion of cause of 2 No			
VII:	iclen sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		0,4	200	ath (Check only or	ne)	
	Attending Physicien: r death. ector: After this certifica by the funeral director.	- 1º	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatien		4 Nursing	7	ence 6 Other (Spe ow injury occurred	cify)
ion	nding ath. r: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investiga	(Month, Day )	Year) Injury	28c. Injun Worl M 1	k? Yes 2 □ No	1	,,	
Division of	el or Attending Ph s atter death. Il Director: After th id in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determin		y - At home, farm, str (Specify)	eet, factory, office	-	28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dircompletely filled in	edical	29a. Certifier (Check only one)	Physicien: To the best of xaminer: On the basis of examiner and manner state	in-sinn/ in-	and the section of the section of	-tains dende one	a comment of the manager of	tata and alaca, and due	to the equec(e)
	within 2 To the	Σ	29b. Signature and title of certifer	1 21 .		29c. License	e number		29d. Date signed (Mont	h, Day, Year)
			7 7	) rhysic	19n	DG	5769	7	10/14	12011
8			30. Name and address of persolar Mohamm	no completed cause of dea	th (Item 23a) (Type, 4 006 7	Print) 070 San	nuel 1	norse la	r Colim	51a 21046
	Sta Registra		31. Date filed (Month, Day, Year)	2011 32. Registrar's	s Signature	arkel				h. Pay, Year)  2011  51a 21046

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time as Death Physician/ Mildred Elizabeth Cannon October 2011 5:05 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 217-44-0065 94 Director 1 🗌 M 2 🗶 F June 10 1917 Usual Residence of Deceder Washington, DC show 10a. State 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland 1 X Yes 2 No Talbot Easton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 33003 Lovedays Lane 21601 United States death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🗷 No Specify "natural", Specify: 3 M Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Administrative Assistant U.S. Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter Clyde Bishop Shaffer Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 s ment of Health a ant: If item 27 i Doris Gerlach / Niece 33003 Lovedays Lane, Easton, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 

Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department Important: Il any injury or once. 4 ☐ Donation fo ☐ Other (Specify) Cedar Hill Cemetery 10/12/11 Suitland, Maryland 21. Signatur f Fy eral Ser ice Licen Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville 5038. Laytonsville. 20882 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 10 days shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Aspiration pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) tran and that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an has page performed? Yes 2 No certificate 2 🗌 No Dementia 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) M. Rokert sin October 9, 2011 D 04115 30. Name and address of person who completed cause of death (Item 23a) pe, Print) 19 201 Russell Ave., Gaithersburg, MD H. Robert Birschbach, M.D. 20877 31. Date filed (Month 32 Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	aryland					and M	ental Hy	giene	0.0		0.1.1	
	_		Registrar  1. Decedent's Name (First, Middle, L	ast)		Cen	tificate	of D	eath		2. Date of Dea	Re <b>g. No</b> ath	20		3 4 5 3. Time of D	eath
	Physicia Medic	in/	ELISE COLEMAN								10/07/		ĭ	'ear	2:20	
or many	Examir		4a. Facility Name (if not institution, gi Montgomery Hospi		ouse			Town, or	Location o	f Death			. County of ontga		,	
*	Funeral Director		124-24-6521	1 DM 0 XE	e (In yrs. last 80	<i>birthday)</i> Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 10/11/	y, Year)		Birthp Count	lace (State or F ry)	oreign
	and show	Ď	Usual Residence of Decedent  10a. State  10b. County		10c. City, T		ation							1	0d. Inside City	
	Mary 28a-f	Director	MD Montgon	ery ————	Rockv	rille	1								1 X Yes 2	□ No
	with the	Funeral D	10e. Street and Number 4612 Bel Pre Roa	ad			10f. Zip 208	853				US.	tizen of Wha	at Coun	try ?	
9036	1 and 2 should be filed within 72 hours after death with the Maryland f Heatht and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  ※ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces 1  Yes 2 If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - Black, Specify:	White, e	etc.	
Baltimore, Maryland 21215-0036	within 72 hou giene. <b>ier than "nat</b> <b>i, the Medica</b>	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 8th		54)	16a. Deced (Give k life. DC <b>Teach</b>	ind of worl O NOT use	k done di retired)	uring most	of workin	g	Chi	ind of Busin ldren rning	's		
land 2	ould be filed within and Mental Hygiene. marked other the imatic event, the I	(a)	17. Father's Name (First, Middle, Las Sam Scott	t)					18. Mothe		(First, Middle, Parsons	Maiden				
Mary	d 2 should alth and Me		19a. Informant's Name/Relationship Deporah J. Colem			19b. Mailin <b>4612</b>	g Address Bel 1	(Street a	nd Numbe Road ,	r or Rural	Route Numbe	r, City or	7 Town, Stat	te, Zip C	code)	
nore,	age 1 and 2 int of Healt it: If item 2 y or other		20a. Method of Disposition  1 X Burial 2 Cremation 3			ce of Dispos netery, chem					ate (0.03.3		ocation - C			
Baltin	permit. Page 1 a Department of I Important: If ite any injury or of		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice	1	uce		. Name and	d Addres	s of Facilit	y Sno	/2011 wden Fi t, Rocl	uner	al Ho	me		
r	110		23a. Part 1. Enter the disease, or co shock, or heart failure. List only			o not ente	r the mode	e of dying	, such as	cardiac o	respiratory ar			$\Box$	Approximate Interval Betwee Onset and De	
St.	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chronic  Due to (or as			re Pu	1mon	ary [	)isea	se			+	Onset and De	
	Examiner	er	Sequentially list conditions,	b. Due to (or as	a consequen	nce of):					-··	_		+		
	ficate be executed g physician and as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequen	ace off:								-		
09	e be exe ysician ne burial	edical E	resulting in death) Last	d										$\perp$		
Box 687	death certi he attendin led for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 Fetal d	leath 3 ⊑	Ectopic p		у				23d. Date Mont		ery Day Ye	ar
s, P.O.	ires that the signed by		Part II. Other significant conditions	contributing to death b	out not resulti	ing in the u	nderlying o	cause giv	en in Part	1.					ne cause of dea	
Division of Vital Records,	the Hospital or Attending Physician: The law requires that the hin 24 hours after death, the Funeral Director. After this certificate has been signed by t mpletlely filled in by the funeral director, page 2 should be detach	Completed by									24a. Was auto perfo	psy ormed?	pri de	or to co ath?	psy findings av mpletion of car 2 <b>X</b> No	railable use of
tal	cian: 7	Be	25. Was case referred to medical examiner?	Hospital:				Otho	ace of Dea							
n of Vi	ding Physi h. After this of funeral dir	ate: To	1 Yes 2X No  27. Manner of Death 1 X Natural 5 Pending	1 ∐ Inpati 28a. Date of inju (Month, Da		R/Outpatien Bb. Time of injury		8c. Injury	4 LJ Nu at	2	ne 5 Resi				hospic	<u>e                                     </u>
<b>Divisio</b>	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific completely filled in by the funeral director.	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be		e, farm, stre			100 2 2		28f. Location ( City or Tox	Street ar wn, State	nd Number e)	or Rura	Route Numbe	er,
	thin 24 hours at the Funeral I ompletely filled	Medical	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practitioner: To th	examination a	nd/or invest	igation, in a	my opinio	n. death or	ccurred at	the time, date a	and place	e, and due t	o the ca	use(s) and man	ner stated
_	5 ≥ 5 0 V		29b. Signature and title of certifier	1				. License				29d. Da	ate signed (	Month,		
	20		Body	ph.	looth /lt 01	20) (5:		6063	4			10/	/07/20	)11		
			30. Name and address of person wh Bindu C. Joseph					hing	rton,	DC: 2	20017					
	Sta Registr		31. Date filed (Month, Day, Year) <b>OCT 14 20</b>	32. Registr												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:30 Joseph Emerson Craig 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air Brightview Assisted Living 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** April 30 Months Days Hours Min. Maryland 214-01-7955 1 ₹ M 2 □ 1917 94 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 ☐ No Havre de Grace Harford Maryland 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number U.S.A. 23a ( 21078 Funeral 705 Alliance Street death or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates. 1 Never Married 2 Mamied 2 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify White 3 ♥ Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business Industry Dept. of Defense Aberdeen Proving 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Ground Elementary/Seconday (0-12) College (1-4 or 5+) Aberdeen, Maryland Chief of Civilian Personnel Four Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) E. Jane Bradfield Robert Bruce Craig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 shument of Health a tant: If item 27 is 453 Congress Avenue, Havre de Grace, Maryland 21078 David R. Craig (son) permit. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Port Deposit, Maryland Asbury Cemetery 10/14/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licensee homas Mitalet Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably W Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed hin 24 hours after death.

the Funeral Director: After this certificate in maleted filled in by the funeral director, pag 2 🔀 No 2 X No 1 Yes 26. Place of Death (Check only one Assisted Living Facility **Division of Vital** 25. Was case referred to medical Hospital or Attending Physician: Be Other: 2 X No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei 2 Umdedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registrar

State

30. Name and address of person who completed cause of de

filed (Month, Day,

eath (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:25 a.M BOBBY LEE CASSADA 20, October 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Moran Manor Nursing Home Allegany Westernport Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 1 X M 2 □ F Months Days Hours 226-46-6471 Dec. 23,1935 Crewe, VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1435 Ludwick Street 26726 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \mathbb{X} Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Superintendent of Operations Power Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Cassada Beatrice Bible 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Cassada/Former wife 1435 Ludwick Street Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Oct. 22, 4 ☐ Donation 5 ☐ Other (Specify) Smith Funeral Home Crematory Keyser, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final CO RM ANY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2 🛱 No 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Examir P.O. Box 68760, Physician/Medical

**Physician** 

/Medical

Examiner

Director

Funeral

\$

Completed

Be

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**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination untiled at once.

Maryland 21215-0036

Baltimore,

ending physician and use as the burial-transit page

3

Completed

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Medical Certification: To

aftending p been signed by the should be detached certificate has director, After this c funeral dire To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur

Division of Vital Records,

State

25. Was case referred to medical examiner? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 29d. Date signed (Month, Day, Year) 021244 10/21/2011

Jesus Tan, M.D. 4 Broadway Frostburg, MD

31. Date filed (Month, Day, Year)

OCT 28 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Crudup 5 :50P 0 ctober 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 246-60-9793 Hours **Director** 1 **X** M 2  $\square$  F 73 05/10/1938 NC Usual Residence of Deceder 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. Director 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Temple Hills 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I 4905 Colonial) Dr. 20748 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Crudup Mattie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose C. Crudup 4905 Colonial Dr., Temple Hills, MD 20748 / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donalion 5 ☐ Other (Spe Resurrection Cemetery 10/17/2011 Clinton, MD 21. Signat 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleratic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to in models cause. Enter Underlying Examine Tax to (or as a nonsequence by Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ jo in the past 12 months? Pregnant at time of death
Unknown been signed by the a should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? Was an cate has l autopsy 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 6 Mother (Specific Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be filled in by the Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRNapalne M.D 10/12/11 D0057465

State Registrar 2835

32. Registrar's Signature

Smith AV

Baltimore MD21209

8 203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D

31. Date filed (Month, Day

OCT 1 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Barbara Renard DeVan 2011 October 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens of Columbia Columbia Howard 8. Date of Birth (Month, Day, Year) Dec 2, 1928 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. Min. Days Hours 218-26-1013 Director 1 □ M 2 F PA 82 28a-f shov 10a. State the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Ellicott City Howard 1 Yes 2X No 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral with 1 4555 Bonnie Branch Road 21043 United States Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Howard County (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Instructional Assistant Public Schools traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Goff George Sherman Renard Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If Item 27 is any Injury or other trau once. 4555 Bonnie Branch Road Ellicott City, Maryland21043 Brian W. DeVan/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svc. 10/17/2011 | Hanover, Maryland Surflure of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family F.H. 4112 Old Columbia Pike Ellicott City, MD 21043 uanuta Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 15 Vears Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease years Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to or as a consequence of and burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) should be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 autopsy performed? certificate 2 X No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Safter death.
al Director: After this ce 2 No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Praditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 17, 2011 D56531

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed

OCT

Harry Li, MD
31. Date filed (Month, Day, Year

21045

Columbia, MD

cause of death (Item 23a) (Type, Print)

32

8699 Snowden River Parkway #301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 10707/2011 ELMORE DAVIS, SR. 1:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Senior Savior Care Montgomery Bethesda If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth MD Country) 9. Birthplace (State or Foreign Sex 1X M 2 □ F Age (In vrs. last birthday) **Funeral** Days 02/12/193] Director 215-26-3042 80 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12617 Tobytown Drive 20854 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Recycle Paper Company ould be filed with nd Mental Hygien marked other the Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henson Davis Maggie Martin and 2 should the Health and Metem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Mildred Hill/wife 12124 Flag Harbor Drive, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)

Gate of Heaven Cem-20c. Location - City or Town, State 1 X Burial 2- Cremation 3 Removal from State 10/18/2011 Silver Spring, MD Gate 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signature Puneral Service Licen 246 N. Washington St., Rockville, MD 20850 23a Part 1 Enter the disease or complicat s that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only Onset and Death

UNKNOWN Immediate Cause (Final disease or condition Atherosclerolic (ardiovascular disease Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last and attending physician and for use as the burial-tr Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 9 Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 signed b þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Adult failure to thrine Hypertension 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performe certificate 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medic 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 🗀 Pending work? 1 ☐ Yes 2 ☐ No Accider Suicide Accident Investigation Could not be 6 🗆 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43121 howde CHOWDHURY, MD; 15216 DINO DRIVE, BURTONSVILLE, MD20866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yellar Physician 9 201 T 1:45pEna /Medical В. Dunbar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Warwick, MD 36 Main St. Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 □ M 287 F Director 8-22-1938 Jamacia, 111-32-8613 W.T Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ehoo the Medical Examiner roust be notified at Yes 2 No MD Director Ceci1 Warwick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 36 Main St. 21912 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after d il Hygiene. other than "natural", or item Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>۾</u> 3 X Widowed 4 ☐ Divorced black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing nd 2 should be filed value and Mental Hygie 27 is marked other in traumatic event, it nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic events. Clarence Lawson Beatrice (Stewart) Lawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Audrey E. Dunbar 36 Main St. Warwick, MD 21912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Mem Pk 9/23/11 NewCastle, DE 21. Signature of Funeral Socio The House of The Wright Mortuary & Services 208 E. 35 h St. Wilm. Mortuary & Cremation DE 19802 Approximate Interval Between Onset and Death 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alche **Physician** ine /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and ched for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 212 No 2 No 1 Yes sepital or Attending Phyalcian: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, ps 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

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shain, 25

32. Registrar's Signature

Baheminter Cecilton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Bruce Olo

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Physician 11:30 AM Leonice Dean 0ct 17 2011 Frances /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline 13266 Holly Road Greensboro If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Dec 8 1924 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🕅 F Maryland 176-20-5956 86 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninar must be notified at once. 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Funeral Director Greensboro Maryland | Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21639 USA 13266 Holly Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. ò Specify: White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk and carrier US postal service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Higdon DeCoursey Gernert ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13266 Holly Road; Greensboro, Maryland 21639 William J. Dean, Sr. son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery Oct 19 2011 Greensboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licenses 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final acute renal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 150 Nassa Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760. physician Physician/Medical the aftending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent premant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Dementi 2 1 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number GM= 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston 21655 3683 ( moterx Rd Butter Welinda 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State 18 2011

DHMH 17 Rev 1/2001

Registrar

Registrar DHMH 17 Rev 7/2009

State

SHAHNAWAZ

31. Date filed (Month, Day, Year)

KHAN,

Box 68760

P.O.

Division of Vital

32. Registrar's Signature

2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD

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Physicia	1/	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month		Ž, 20	o <sup>v</sup> řaí	3. Time of 8:30	Death
Medic Examine	al	Tibor J.  4a. Facility Name (if not institution		nber)		4b. City, Town, or Location of Death						4c. County of Death			ам
Examilia	= 1	Brighton Gard						Bethe					gomer	У	
Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.		er 1 Year	If Under Hours		8. Date of Bir (Month, Da Oct • 21	Birth 9. Birthplace (State or Fore				Foreign
Director		579-50-9396 Usual Residence of Decedent		86	1(5.							,1924 Hungary			
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r 28a- notifi	<u>Pir</u>	DC n  10e. Street and Number	one	h	lashing	ngton, D.C.						Citizen of W	Vhat Count	1 🔀 Yes	2 L No
with the 23a c	Funeral Director	4423 Garrison	Street, N	. W.		101.2	200	)16				USA	viiat oouii	y :	
death items ner m		11. Marital Status	12. Was Dece	edent Ever in U		Vas Dece	edent of H	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)			e - America k, White, e		
be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes 2X No										ite			
72 hours 1 "natur edical B	olete	15. Deceder	nt's Education est grade completed		16a. Deced			ation during mos	t of work	ina	16b.	Kind of Bu			
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iled wi I Hygie o <b>ther</b> /ent, tl	To Father's Name (First, Middle, Last)  5+ Retail Sales Manager Department Sto  18. Mother's Name (First, Middle, Maiden Surname)										Broie				
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pernit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		State M	cemetery, cren etropo remato	natory or Lita: rv	other plac <b>n</b>	ce)	Oct. 201	12	   <sub>A14</sub>	exand	ria.	Va.	
permit. Departi Import any inji		21. Signature of Funeral Service	icersee// MO1		22	. Name a	and Addres	ss of Facilit		eVol Fu	nera	al Ho	me		
	1	23a. Part 1. Enter the disease, or	complications that	caused the dea						N.W.		ningt	on, I	O.C. 20	
Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on ea	onary A										Interval Bety Onset and D	ween
) Medical Examiner		resulting in death)		(or as a conseq		ISE	ise								
	ے ا	Sequentially list conditions, if any, leading to immediate		ertensi									_		
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To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical		d												
nding use as	Ž	IF FEMALE: 23b. Was decedent pregnant		come of pregn		] e						23d. Dat	te of delive	ry	
death he atte ed for	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 ☐ Fet nant at time of nown		Other (s	pregnancespecify)	;y 				Мог	nth	Day Y	ear/
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uires th	<u>a</u>									1 🗆	Yes :	2 🔀 No	3 🗍 Prob	ably 4 🗆 l	Jnknown
as beer 2 shou	Completed									24a. Was		24b. V	Were autop	sy findings a	ıvailable ause of
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g Physer this eral di	<u> </u>	1 ☐ Yes 2 🙀 No 27. Manner of Death	28a. Date		28b. Time of		DOA 28c. Injury	4 l <b>xt</b> Nu ∕at	ursing Ho	ome 5 Resi 28d, Describe					
eath. or: Aft	ical	1 X Natural 5 Pendin 2 Accident Investig	gation	th, Day, Year)	injury	М	work 1 🗆	? Yes 2 🗆	] No						
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To the Hospital or within 24 hours after To the Funeral Director Completed filled in	edical		Physician: To the b												
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C 2 2 2 2		29b. Signature and title of celtifier	0.	_		29	b. License					ate signed			
•	-	30. Name and address of person v		e of death (Item	n 23a) (Type. P	rint)	D301	32			0c	tober	12,	2011	
		M.Rita Ghosh,	M.D. 1	4812 P	hysici	ans	Lane	#161	, Ro	ckville	, M	d. 20	850		
State Registra		31. Date filed (Month, Day, Year) OCT 14	2011	egistrar's Signa	J. pa	فعيص	,								

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 34524 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 15 **Physician** 2011 04:10A M Oct June Idabelle Embrey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Caroline Home for Hospice Denton 8. Date of Birth (Month, Day, Ye April 6, 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Year) 1941 **Funeral** 1 □ M 2 🗓 F Months Days Hours Washington, DC 70 Yrs 218-38-6971 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Caroline Henderson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 25030 Bee Tree Road 21640 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify: Specify: à 3 → Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Embrey 25030 Bee Tree Road; daughter Henderson, Maryland 21640 Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation Oct 22 2011 Stevensville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PO Box 160; Greensboro, MD 2163 Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Ambu Months actor. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate NS 1 ☐ Yes 2 ☑ No 1 □Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 29a, Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. WASHINGTON ST, EASTON MD 2160 LAKSHMI 219 D THAN 32. Registrar's Signature State Registra

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	-	<b>1 - State</b> Registrar  State of Maryland / Department of Health ar  Certificate of Death	nd Menta	al Hygien Reg. N		34525				
Physician/ Medica		Decedent's Name (First, Middle, Last)     ALBERTA JULIA WITHERS FRENCH	_Mo	e of Death	10, 2011	3. Time of Death 11:17 A M				
Examiner	r	4a. Facility Name (if not institution, give street and number)  Laure   Regional Hospital   Laure    5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24	Death 4 Hrs. 8, Dat	e of Birth	C. County of Death	George's  hplace (State or Foreign				
Director		218-24-6918 1 M 2 XF 93 Yrs. Months Days Hours Usual Residence of Decedent	Min. 10/Mc	01/1918	MD <sup>Col</sup>	intry)				
or 28a-f show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 1 Ves 2 □ No				
a or 28 be noti		10e. Street and Number 10f. Zip Code		ľ	Citizen of What Co	/hat Country?				
eath with	runerai	16630 Brogden Road 20868  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin			14. Race - Amer	ican Indian,				
rs after de ral", or it Examine	2	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, specify Cuban, Mexican, F  1 ☐ Yes 2 ☑ No Specify:	Puerto Rican, e	etc.)	Black, White Specify: Black	, etc.				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  5+ vears  16a. Decedent's Usual Occupation (Give kind of work done during most or life. DO NOT use retired)  Teacher	Mo	Kind of Business ontgomery	County					
Maryland 21218  0 2 should be filed within 72 alth and Mental Hygiene. 27 is marked other than "is traumatic event, the Mes		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  17. Father's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)								
Mary d 2 should alth and h 27 is ma		19a. Informant's Name/Relationship (Type, Print)  Nancy M. Barber/daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  16630 Brogden Road, Spencerville, MD 20868								
more,		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cymetery, crematory or other place)  Arlington Cemetery	Date		Location - City or					
Balti permit. F Departm Importa any inju once.		21. Signature Funeral Service 1 22. Name and Address of Facility 246 N. Washingto	Snowd	en Fune	eral Home	<u> </u>				
Physician/		23a. Part 1. Enter the disease, or combinations that caused the death Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Mocardial Infarction				Approximate Interval Between Ons t and Death				
Medical Examiner		Due to (or as a consequence of):								
xecuted n and sh-fransit		if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events C.								
760  cate be executed physician and s the burial-transit	1 E	resulting in death) Last  Due to (or as a consequence of):  d								
6876 ertificate ding phy se as the		IF FEMALE: 23c. If yes, outcome of pregnancy								
y, P.O. Box 68' s that the death certific gned by the attending be detached for use as by Physician/M	in yalcıdı	23b. Was decedent pregnant in the past 12 months?  1			23d. Date of del Month	Day Year				
dS, P.C luires that the signed build be detailed by P.C	62 23	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes	23			the cause of death?				
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and ronpleted filled in by the funeral director, page 2 should be detached for use as the bural-transit Medical Certificate: To Be Completed by Physician/Medical Exam		- Hypertension	_	a. Was an autopsy performed? Yes 2	prior to death?	copsy findings available completion of cause of				
Vital hysician: his certific Il director,	3 3	25. Was case referred to medical examiner?  1			6 ☐ Other (Spec	4.1				
on of North ording Phy Lith.  : After this of funeral cate: T	2	27. Manner of Death    1	28d. De	scribe how inju		iy)				
Division of all or Attending P s after death.  Director: After t d in by the funeral Certificate:		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		cation (Street a or Town, Stat	und Number or Rui te)	ral Route Number,				
ne Hospitu n 24 hours ne Funera pleted fille	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the within To the Corn.		29b. Signature and title of certifier 29c. License number		29d. D	ate signed (Month					
	3	30. Name and address of person who completed cause of death (Item 3a) (Type, Print) 7300 Valor Thomas H. Burquieres, MD Laurel Regional Hospital,	in Dus Emeros	en Rd	· Laur	el, MD 20707				
State Registrar	3	31. Date filed (Month, Day, Year)  OCT 14 2011  32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34526 Reg. No. 20 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Rhoda Lauer Fabiszewski October 11, 2011 5:20 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Numbe If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 215-12-5143 **Director** 1 □ M 2 ☐¥ 88 Jan. 29, 1923 MD 28a-f shov 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits at the Maryland Director notified 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral with 3118 Gracefield Road, CCT 18 20904 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, and Mental Hygiene.
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aumatic event, the Medical Examiner. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after Specify: White 1 ☐ Yes 2 A No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ 12 Homemaker Own Home traumatic event, Be Department of Health and Mental His Important: If then 27 is marked oth any injury or other traumair: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick B. Lauer Augusta P. Matthai 19a. Informant's Name/Relationship (Type, Print) -Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Edward Fabiszewski, 3118 Gracefield Road, CCT 18, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1x Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. Grove Cemetery 4 Donation 5 Other (Specify) Mt. Airy, MD 21. Signature of Funeral Service Francis Addres Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a Paril . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ Cardiac Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Complete Heart Block one week Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Coronary Artery Disease <u>two weeks</u> that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2X No signed by the a Id be detached I g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Abdominal Aortic Aneurysm 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 🗓 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 XNo Other: မ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work?
1 Yes 2 No within 24 hours arter co...

To the Funeral Director: After 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and litle of certifle 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

Garry Ryben, MD

OCT 14

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D21153

1500 Forest Glen Road, Silver Spring, MD 20910

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34527 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1704 M Fleurissaint Vilsaint 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death he Memoria Easton 1 AI BOT 8. Date of Birth (Month, Day, Year) 20, 1952 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Hours 593-32-4919 Director 1**X**] M 2 □ F 59 Jan. 20, Haiti Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Caroline Federalsburg 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21632 210 Academy Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner I Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Black 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education. 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Poultry Processing Sanitation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FLELLERISAINY ပ Bauvit Fleurissaint Amenie Bacone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Fleurissaint/Spouse 210 Academy Ave., Federalsburg, MD 21632 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 10/22/11 Federalsburg, Maryland 4 Donation 5 Other (Specify) Federal Hill Cemetery 22. Name and Address of Facility Framptom, Funeral Home 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Ronal acute and Chronic Ph\_sician/ disease or condition Medical resulting in death) SAI Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequent of Examin and resulting in death) Last attending physician I for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 HNO 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manne eath 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending after death.

Director: Af 2 Accident
3 Suicide 1 Yes 2 No Investigation within 24 hours after des To the Funeral Directon completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 315Y6 m Trus 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) 1201145 · Na Blo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 0 2011

DHMH 17 Rev 06-2011

Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ 1:07 ROBERT CAMPBELL **GARY** A M **OCTOBER** 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2011 Brighton Road Avondale Prince Georges If Under 1 Year | If Under 24 Hrs. Social Security Number g. Birthplace (State or Foreign 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Days Hours Months 1/7"/1"9"3"5 Fl 76 Vrs Director 261-44-4449 Usual Residence of Decedent 28a-f shov 10a. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits the Maryland Director must be notified 1 Yes 2 □ No MD Prince Georges Avondale ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA Brighton Road 2011 20782 death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. o. ò 1 Never Married 2 Married 1 X Yes If Yes, Giv 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates. **KOREAN** Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Conciliar Penal Institution (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mee Elementary/Seconday (0-12) College (1-4 or 5+) DC Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown ၉ Pearlie Icie Hendley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 Brighton Rd. Avondale,MD 20782 Ruby Gary/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cheltenham 1 Burial 2 Cremation 3 Removal from State 10/17/11 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Annaea 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 3831 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) METASTATIC PROSTATE CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir B To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Year Month Day Pregnant at time of death 2 No Unknown 9 Unknown as been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESSENTIAL HYPERTENSION 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of DIABETES MELLITUS TYPE II 24a. Was an has autopsy page performed? Yes 2 No death? certificate I 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 5 Residence 6 Other (Specify) 1 Yes 2 X No 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending s after death.

I Director: Aff 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a

To the Funeral D edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number OCTOBER 12, 2011 MD# 33255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year, alle Registrar's Sign State 1 4 2011 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar 34529 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Christine Elizabeth Garner oct. 9, 2011 Year Medical 10:30p M 4a. Facility Name (if not institution, give street and number)

Crescent Cities Center 4b. City, Town, or Location of Death **Riverdale** Examiner 4c. County of Death Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Washington DC If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F 99<sub>Yrs</sub> Months Days Hours Min (Month, Day, Year) 578-62-2360 Director Dec. 1911 Usual Residence of Decedent 10c. City, Town or Location College Park ms 23a or 28a-f show must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits Director MD Prince Georges 1 Yes 2 No 10e. Street and Number 10f. Zip Code Citizen of What Country? Funeral 7518 Creighton Drive 20740 United States nit. Page 1 and 2 should be filed within 72 hours after death w artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items: injury or other traumatic event, the Medical Examiner mu 11 Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc þ Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify. If Yes Give Specify: A merican 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Teacher D.C. Public School College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Addie Ellen Carter ပ Wilbert Garner permit. Page 1 and 2 should be Department of Health and Merr Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3366 Blaine Street, NE, Washington DC 20019 Margaret E. Garner Watts tox 20a. Method of Disposition 20c. Location - City or Town, State
Suitland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/17/2011 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cemi 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 sudre hor Boon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ALZHEIMERIS EMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-trangit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) fo in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Then tendion 1 ☐ Yes 2 🔊 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 N death? this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D01852 October 10,2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ducen's bury Rd Hy GHTSVIlle MD 901 DE Ms 31. Date filed (Month, Day, Year)

OCT 14 2011 Registrar's Signature. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ October 7, 2011 Morris Willmore Holland 2:43 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Prince Georges** 7519 Riverdale Rd. Apt. #1945 New Carrollton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign June 26, 1937 MD Director 215-34-2915 74 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10a, State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Prince Georges **New Carrollton** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7519 Riverdale Rd. Apt. #1945 USA 20784 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2☐ No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert M. Holland Ruth L. Jones 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2650 McDaniel Rd, Waldorf, MD 20603 James R. Holland - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Plum Pt.UMC Cem. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/201 Huntingtown, MD Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Blade 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician perten disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown has been signed to should be 24b. Were autopsy findings available prior to completion of cause of death? JOUT 24a. Was an After this certificate har funeral director, page performed? Yes 2 No 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) exeminer? 1 Yes Hospita 2 🗌 No Other: မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of c

JRW |

DHMH 17 Rev 7/2009

Registrar

Cheverly, MD

ums

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

OCT

Linda Green,

31. Date filed (Month, Day, Year)

			For State of Mar	yland				and M	ental Hy	giene	011	21.521	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cen	tificate of	Death			Reg. No.	UII	34531	
а	Physicia		JOHN E. HI	i.I.					2. Date of De Month OCT.	nath Day	$20\overset{\text{Year}}{11}$	3. Time of Death 7:50 A M	
~	Medi Examir		4a. Facility Name (if not institution, give street and number)			4b. City, Town, o	or Location o	of Death	001.		unty of Death	7.50 A	
~		ш	HOLY CROSS HOSPITAL					R SPRING MONTGOMERY					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (1. 219−30−4219 1 🛛 M 2 ☐ F	n yrs. last		If Under 1 Year Months Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birthr Coun	place (State or Foreign try)	
			Usual Residence of Decedent	75	Yrs.				FEB. 1	7,1936	MAI	RYLAND	
	ıryland t-f sho ied at	Director		Jc. City, To	own or Loca						1	0d. Inside City Limits	
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	with t	Funeral	2401 GLENALLAN AVE. #104				906			Ü	U.S.A.	y .	
	death r item ner m	Fur	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S.	13. W	as Decedent of H Yes, specify Cub		gin? (Speci	ify Yes or No-	14.	Race - Americ Black, White,		
036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 📈 Married 1 ☐ Yes 2 💹 No If Yes, Give Year or Dates,			☐ Yes 2 🎇 No					ecify: BLA		
2-0	Phour	plete	15. Decedent's Education (Specify only highest grade completed)	1	16a. Decede	ent's Usual Occup	oation	. Commission		16b. Kind	of Business/Inc		
121	thin 7; ene. than he Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	$\dashv$	life. DO	nd of work done NOT use retired)			3	. по	am ann:		
d 2	Hygie other	Be	17. Father's Name (First, Middle, Last)		<u> </u>	ETTER CA			First, Middle,		ST OFF	LCE	
ylar	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	မ	JOHN E. HILL SR.						OROTHY		ORREST		
Mar	shoul		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Street	and Number	r or Rural I	Route Numbe	r, City or Tou	ın, State, Zip C	Code)	
9	and 2 Healtl tem 2		GUSTINA D. HILL/WIFE  20a. Method of Disposition			SWEET A	AUTUMN :					MD.20879	
ē	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ceme	etery, crema	atory or other place  CREMATOF		Da	-2011		ion - City or To $\mathbf{DALE}$ , $\mathbf{N}$		
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	OHH		Name and Addre							
_	20 <b>5 8 8</b>	-		M000	91   28	OT CLEAF	LAND .	AVE.,	RIVE	RDALE,	MD. 20	737	
	de cicion/		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									Approximate Interval Between Onset and Death	
	h sician/ Medical		disease or condition resulting in death)  disease or condition a. POORLY DIF			ED SQUAM	IOUS C	ELL (	CANCER	OF LU	NG	Onsor and Boarn	
THE STATE OF	Examiner	_	Sequentially list conditions, b.										
	g an	Examine	if any, leading to immediate Due to (or as a co	risequenc	ce oŋ:								
	xecute	Exar	Cause (Disease or injury that initiated events c. Due to (or as a corresulting in death) Last Due to make a corresponding to the corres	nsequenc	ce of):								
9	ate be executed onlysician and the burial transit	dical	d										
687	irtificat ling ph	/Mec	IF FEMALE:										
ROX	requires that the death certifica been signed by the attending ph should be detached for use as t	Physician/Me	23b. Was decedent pregnant   23c. If yes, outcome of print in the past 12 months?   1 Ure 3 No   4 Pregnant at tin	Fetal de	eath 3 🗌	Ectopic pregnand Other (specify)	су			23d	. Date of delive Month	ery Day Year	
о Б	the de by the tached	hysi	9 Unknown										
	ss that the igned by ti be detach	þ	Part II. Other significant conditions contributing to death but n	ot resultin	ng in the und	derlying cause gi	ven in Part I.					e cause of death?	
Sp.	requires been sig should b	eted	ATRIAL FIBRILLATION									ably 4 🗌 Unknown	
ö	las e 2	Completed	COPD						24a. Was autor		4b. Were autop prior to cor death?	ssy findings available npletion of cause of	
で 同	an: Th tificate tor, pa		25. Was case referred to medical	-		26 PI	ace of Death	(Check o	1 Yes		1 Tes	2 🗌 No	
N I I	hysici his cer	유	examiner? 1 ☐ Yes 2 【XNo Hospital: 1 X Inpatient	2 🗆 ER/	Outpatient	LOth	er.			dence 6 🗆	Other (Specify)		
וס ח	ding P h. After t funera	ate:	27. Manner of Death  1 X Natural 5 ☐ Pending  28a. Date of injury (Month, Day, Ye		o. Time of injury	28c. Injury work	?		d. Describe h	ow Injury oc	curred		
VISION	Atten	Certificate:	2	At home,	farm, stree		Yes 2 ☐ I	-	f. Location (9	Street and Nu	mber or Rural	Route Number,	
<u> </u>	tal or ins afte al Dire	ဦ ြ	building, etc. (S	oecify)		,		1	City or Ton				
	to the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of exam	ination and	d/or investia	ation, in my opinic	on, death occ	curred at the	e time, date a	nd place, and	due to the cau	ise(s) and manner stated.	
	vithin comple	Σ	only one) 3 Certifying Nurse Practitioner: To the be 29b. Signature and the beautiful or sertifier	st of my kr	nowledge, d	eath occurred at t		and place	e, and due to t		nd manner as s gned (Month, E		
	<b> </b>		151			D62					. 13, 2		
			30. Name and address of person who completed cause of death			nt)							
	State		DR. SARAH BROMELAND, M.D.  31. Date filed (Month, Day, Year)	Signature	1500	FOREST	GLEN I	RD.,	SILVE	SPRI	NG, MD.	20910	
	Registra	r	31. Date filed (Month, Day, Year) OCT 14 2011	A.	par								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 2011 2:54 a Physician/ Lucille K. Henault Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Severna Park 6 White Oak Court g. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea May 21, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Hours **Funeral** Pennsylvania 1935 1 □ M 2 😾 F 76 **Director** 162-28-6249 10d. Inside City Limits 10c. City, Town or Location or 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Severna Park Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA Funeral 21146 6 White Oak Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2 X Married Yes 2 X No ģ Specify: White 1 Yes 2 No Specify: Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Home Homemaker 4 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) and Mental His marked of Laura Magrowski ပ္ Henry I. Hummel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severna Park, MD 21146 permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any Injury or other trau once. 6 White Oak Court Emile Henault/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 12, Oct. 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 2011 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy. Sign e of F end Service Ligensee Severna Park Funeral Home Severna Park, MD 21146 Paul 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 23a. Part. Enter the disease, Interval Between Onset and Death Immediate Cause (Final disease or condition Pl., i.ian/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed and Due to (or as a consequence of): burialng physician a Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery use 23b. Was decedent pregnant Month Year in the past 12 months?

1 Yes 2 No
9 Unknown for signed by the a Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tyes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performe 1 Yes Yes Hospital or Attending Physician: The 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Pesidence Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner Certificate: Pending Matural Investigation 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after deat Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Norse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one)

within 2 State Registrar

of person who completed cause of death (Item 23a) (Type, Print) 25 Ridgely Ave

29b. Signature and title of certifier

29d. Date signed (Morfith, Day, Year)

Annapolis, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Eugene Hickman, Sr. 2011 October 2:45 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9 Washington Street North East Cecil Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Oct. 24, 1934 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. 212-32-4741 76 Yrs Maryland Director Usual Residence of Decedent 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Cecil North East 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Washington Street 21901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married ğ 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Cecil County Board of (Specify only highest grade completed) of Health and Mental Hygiene.
of Health and Mental Hygiene.
of item 27 is marked other than "n
other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Education Custodian Six Years Elkton, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ဂ္ Lester Hickman Elsie Barrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once. Velma F. Hickman (wife) Washington Street, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) R.A.Ferris & Co., Inc. 10/12/11 Pennsylvania Lee A. Patterson & Son Funeral Home, P Perrvville, Ma<u>ryland 21903-0766</u> Signature of Funeral Service Liven 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Esophagea Onset and Death Physician/ Medical resulting in death) s a cons (que nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed?
Yes 2 X No 2 🔯 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Hospital or Attending after as the burial-transit

use

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detached

ate has been signed by page 2 should be detact

certificate

and

the attending physician

shov

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23a

items

"natural", or

72 hours after

Baltimore, Maryland 21215-0036

To the Funeral Director: After this certific completed filled in by the funeral director, within 24 hours a o

State Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature and title

29c. License number 2000

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jamil Khatri, M.D., 111 West High Street, No. 104, Elkton, Maryland

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2011

11-07936	
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lon Michae	el Jo	nes 1- For State	State of Ma	ryland /		rtment of		and Me	ntal Hy	_	2	011	345
Physici	an/	Registrar  1. Decedent's Name (First,	Middle,Last)		0071	modic or	Dodin	_		Re 2. Date of Deatl	g. No.		of Death
cal Exami		Brandon Mic	chael Jon	es						Month October 21			36 hrs
		4a. Facility Name (if not inst 5018 36th Place	titution, give street ar	nd number)		4	* '	n, or Locatio	n of Death		4c. County of		
E		5. Social Security Number	6. Sex	7 400	(laum las	st birthday)	Hyattsv		nder 24Hrs.	In Date of Diet	Prince Ge		(0)-1-
Funeral Director		217-13-7146						Days Hou		1		Foreign	
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ku a		10a. State 10b. Co		1	0c. City, T	own or Location	on					10d. In	side City Limits
nd thow	_	MD P.	3.		Нуа	ttsvil	le					1 X	Yes 2 No
Maryland 28a-f show d at once,	Director	10e. Street and Number					10f. Zip Co	de		10	g. Citizen of Wha	t Country?	
the N	Ę	5018 36th 1	Place				20	0782			USA		
ted within 72 hours after death with the Maryland stygiene.  other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	uneral	11. Marital Status	_	Decedent E	ver in U.S.					cify Yes or No-		American Indi	an, Black,
or ite	FE	1 X Never Married 2	1 Y		No No			uban, Mexica		(ican, etc.)	White,		
ral",	þ		Divorced If Yes, Given or Dates:					No specif			Specify: V		
hour Exen	ted	15. Decedent's Education Elementary/Secondary (0		grade comp ge (1-4 or 5+		16a. Decedent during mo		cupation (Giv g life. DO NC			16b. Kind of Busi	ness/Industry	
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led within 72 ho Hygiene.  other than "na the Medical Ex	20	17. Father's Name (First, Mi	ddle, Last)			Lands	caper		er's Name (	First, Middle, M	aiden Surname)	scaping	
be file	Be (	Bradley W.	Jones					Ade	ele C.	Barbag	allo		
d Menta d Menta is marke	ို	19a. Informant's Name/Rela						Street and Nu	umber or Ru	ral Route Numi	per, City or Town,		de)
permit. Pages I and 2 should be fill Department of Health and Mental F. Important: If item 27 is marked injury or other traumatic event, in the permit of the marked injury or other traumatic event, in the permit of the marked injury or other traumatic event, in the marked injury of the marked injury or other traumatic event, in the marked injury of the marked injury or other traumatic event, in the marked injury or other event, injury or		Bradley W. J	ones/Fath	er							.11e, MD		
s l an of Hea If iter		20a. Method of Disposition 1 X Burial 2 Crem	ation 3 Remov	al from State		ace of Disposit ematory or other		of cemetery,		Date	20c. Location - 0	City or Town, S	tate
Page nent c		4 Donation 5 Othe		ar irom otato		of Hea	ven C	emeter	<b>V</b> 2	t. 31, 011	Silver S	pring,	MD
epartr nport	Н	21. Signature of Funeral Ser	vice Licensee	0		22. Na Era	me and Add	dress of Facil	lity 1 d n.e.	Funoral	Home In		
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signed by	ā	Part II. Other significant co	nditions - contributir	ng to death b	ut not resu	ulting in the un	derlying cau	ise given in F	Part I.		acco use contribu	-	_
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E -	B B	25. Was case referred to me examiner?					26.P	lace of Deatl					
certif xctor,		1 ✓ Yes 2 No	Hospital: 1	Inpatient		R/Outpatient		Other <sub>4</sub>		Home 5 R	tesidence 6 🗹	Other: Scene	
"nysician: The rthis certificate al director, page	의		28a. D	ate of Injury onth, Day,Year	) 28	8b. Time of Inj	ury 28c.	Injury at Wor	_		w injury occurred		
ing rhysician: After this certif	의: LG	27. Manner of Death	(M		11 .	ınknown	. 1	Yes 2	No lu	nknown			
Attending Physician: death. ctor: After this certif y the funeral director,		1 Natural 5 F	Pending fd	10-21									
or Attending Physician: s after death. 1 Director: After this certif id in by the funeral director,		1 Natural 5 F 2 Accident 3 Suicide 6 X	Pending nvestigation 28e. F	lace of Injur	y - At home	e, farm, street,			etc. 2	8f. Location (St or Town, Sta	reet and Number	or Rural Route	Number, City
oppital or Attending Physician: hours after death. uceral Director: After this certif y filled in by the funeral director,	Certification:	1 Natural 5 F 1 2 Accident 3 Suicide 6 🗷 0	Pending nvestigation Could not be letermined (Special Country of the Country of t	lace of Injury	y-Athomo	e, farm, street, dence	factory, offi	ce building, e	1	or Town, Sta <b>Iyattsv</b>	1110, Md.	6th St	Number, City
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To the Hospital or Attending Physician within 24 hours after death.  To the Funeral Director: After this certi completely filled in by the funeral directon	fedical Certification:	1 Natural 5 F Accident 3 Suicide 6 X (2 Accident 3 Suicide 6 X (2 Accident 4 Homicide 29a. Certifier 1 Certifyln one) 2 Medical 29b. Signature and title of ce	Pending nestigation 28e. F (Special Physician: To the Examiner: On the barand manner tiffer	Place of Injury  ify)  best of my king of examiner stated.	y - At home resinowledge, nation and/	dence death occurre	factory, offind at the timen, in my opi	ce building, e e, date and p nion, death o	lace, and de	or Town, Sta <b>Iyattsv</b> ue to the cause he time, date an	ite) 5018 3 i11e, Md. (s) and manner a nd place, and due	s stated. to the cause(	s)
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			1 - For State Registrar	State o	of Maryland		artment of I				giene ( Reg. No.	)	34535		
	Physic		1. Decedent's Name (First, Middle, Joseph W.		on, Jr.			2. Date of Dea Month October	Day	2011	3. Time of Death 5:06PM M				
1	/Medi Exami		4a. Facility Name (If not institution, 8906 Eastbourn	give street and nu			4b. City, Town, C		of Death		4c. Cou	4c. County of Death Prince George's			
	Funeral Director			5. Sex 1  M 2 ☐ F	7. Age (In yrs. la			If Unde	or 24 Hrs. Min.	8. Date of Birth (Month, Day	h y, Year)	9. Birth Cou	place (State or Foreign		
	ъ	tor	Usual Residence of Decedent  10a. State 10b. County	e George'	10c. City	Town or Lo				July 4	, 1931	North Caroli  10d. Inside City Lir  10dXYes 2□			
	ith with the 23a or 28s	Funeral Director	10e. Street and Number 8906 Eastbourne				10f. Zip Code	20708					10g. Citizen of What Country? U.S.A.		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Modical Examinar must be notified at 2006.	by	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo d 1 ☐ Yes If Yes, Gi	1 ☐ Yes 2 ☐ No			Was Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, et I □ Yes 2 🔣 No Specify:							
21215-0036	within 72 ho ene. than *natur	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+) 4+  Analyst					ost of workin	ng	16b. Kind o						
nd 21	be filed winter Hygien of other the event, the	Be Con	17. Father's Name (First, Middle, Last)  18. Mother's Name  19. Care I								Dept.  Maiden Sum		efense		
Maryland	2 should be and Ment is marked saumatic e	<sup>L</sup>	Joseph W. Johnst	o (Type, Print)	14 E _		ng Address (Street	t and Numb		l Route Numbe					
	Pages 1 and nent of Health int: If item 27 iry or other tr		Sylvia M. Johnston Wife 8906 Eastbourne Lane, Laur  20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of commetery, crematory or other place)  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of commetery, crematory or other place)  Holy Savior Cemetery 10/14/201									20708 on - City or T	own, State		
Baltimore,	permit. P. Departme Important any njury once.		21. Signature of Funeral Service Li				2. Name and Address 7601 Sa	ess of Faci	ility I	Fleck F	uneral	Home	20707		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or control shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	or as a consequ	nc of):					rest,	upenp4)	Approximate Interval Between Onsat and Death		
8760,	cate be executed physician and the burial-transit	dical Examiner	Gaquantially list curiditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseque		<u>m</u>	0011					opbe.		
.O. Box 68	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregnan birth 2  Fetal of nant at time of decome	death 3	Ectopic pregnanc	у				Date of delive	very Day Year		
Ф.	quires that n signed by	by	Part II. Other significant condition	s contributing to d	eath but not resul	ting in the u	nderlying cause gr	ven in Part	11.		obacco use c		the cause of death? bably 4 DUnknown		
al Records,	The law ate has b page 2 si	Completed	<u></u>								an 24 psy rmed? 2 No	b. Were aut prior to co death?	opsy findings available ompletion of cause of		
f Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2 🗆 E	R/Outpatien	nt 3□ DOA Oth	har		(Check only o		Other (Spec	ify)		
ion of	ling After une	ertification:	27. Mann of Death  1 Natural 5 Pending 2 Accident investiga	tion	of Injury th, Day Year)	28b. Time of Injury	Wo	ryat rk? ]Yes 2 [		8d. Describe h	now injury oc	curred			
Division	or Attencater death Director:	ertific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	280. Place							28f. Location (Street and Number or Rural Route Number, City or Town, State)				

Medical Certification; To Be Completed by PI

To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed b completely filled in by the funeral director, page 2 should be detailed.

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 🗌 Unknown

art II.	Other	significant	condition	s contribut	ing to deat	h but not i	resulting in	n the unde	rlying cau	ise given	in Part I

23e. Did tobacco use contribute to the cause of death?									
1 ☐ Yes 2	No	3 Probably	4 Dunknow						
24a. Was an autopsy performed?	24b	. Were autopsy fir prior to completi death?	ndings available on of cause of						

5. Was case referred to medical examiner? 1 Yes 2 No	Н	ospital: 1  Inpatient 2	] ER/Outpatient	3□ DOA	(
7. Mann of Death 1 Natural 5 Pending		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	

d to medical				3. Place of De	ath (Cl	neck only one)				
0	spital: 1 🗋 Inpatient			3 🗆	DOA	Other:	4 🗌 Nursing 🖁	Home	5 Hesidence	6 ☐ Other (Specify)
5 Pending investigation	28a. Date of Injury (Month, Day Yea	2 <i>r</i> )	28b. Time of Injury	М	28c.	Injury at Work? 1  Yes	2 □ No	28d.	Describe how inju	ury occurred

2 Accident	investigation		М	1
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury · At home, farm, stree building, etc. (Specify)	t, factory,	offic

□No	
	28f. Location (Street and Number or Rural Route Number City or Town, State)

	one)			
29b.	Signature ar	nd title	e of	certifie

29a. Certifier (Check only

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 115117

ense number			opin, Day, rear)	
113117	10	6	9011	
Westminste	y Ad	0	1157	-

State Registrar

31. Date filed (Month, Day, Year)
OCT 13 2011

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) Physician/ 2011 KALBAUGH MAXINE ALTA Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany umberlano - Rigional Mudicul Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** (Month, Day, Year) 232-60-5463 1 □ M 2 💢 F Director March 29,1929 Cross, WV 82 Usual Residence of Deced 10d. Inside City Limits 10c. City, Town or Location or 28a-f shov 10a. State 10h County must be notified at Director 1 ☐ Yes 2 💢 No WV Mineral Keyser 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Funeral 23a USA 26726 Rt. 4, Box 532 tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. within 72 hours after death 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) School Cafeteria Cook Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be file of Health and Mental Filem 27 is marked of 2 Roxie Faye Moran Alvie Wilt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HC 72, Box 7260 Scherr, WV item 27 Debra S. Braithwaite/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date . Page 1 Department of Important: If it any injury or o once. cemetery, crematory or other place) Oct. 1 X Burial 2 Cremation 3 Removal from State 2011 Keyser, WV Potomac Memorial Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Smith Funeral Home 26726 WV 85 S. Main Street Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Day Ph\_sician/ disease or condition resulting in death) neumenu Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attending d be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 Probably 4 Unknown 1 Tes page 2 should neec 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy this certificate has performed? Yes 2 X No death?
1 Yes 2 No 26. Place of Death (Check only one) To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospita 1 Yes 2 No ER/Outpatient 3 DOA မှ 1 1 Inpatient 2 ... 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 V Natural work 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical 1 Descriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2011 -7013 JAIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROKET - TAPN 12500 WILLOW BROOK ROAD CUMBERLAND ND -21502 12500 KOHIT NIAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard County General Hospital Columbia Howard Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. 1 □ M 2 🔀 F Months Hours Director 90 1921 Maryland 220-14-8543 Aua Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 🗌 Yes 2 🔀 No Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 United States 12727 Folly Quarter Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Key Punch Operator Rendiv traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental P is marked or Mary ပ Μ. Stine Stephen L. Farrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2 s Health a 12727 Folly Quarter Road Ellicott City, MD 21042 William M. Kelly/husband item 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Important: If it any injury or or on once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lawn Mem. Gardens 10/19/11 | Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitarry H. Witzke's Family F.H. Inc. 21. Sign Iture of Funeral Service Licenses Ellicott City, MD 21043 4112 Old Columbia Pike 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine transit. and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No ☐ Pregnant at time of death
☐ Unknown the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a Was an 24b. Were autopsy findings available autopsy performed Yes 2 prior to completion of cause of าสร death? To the Funeral Director: After this certific: completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 / 100 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) / CENNET MD 30 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $2011^{\text{Year}}$ Mary Alberta Montgomery October 14, 1:55 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 605 Mermais Court Calvert Lusby 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🕃 F Months Days Hours Min. 02/23/1918 Director 93 219-94-6467 Maryland Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 W No Maryland| Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral ?7 is marked other than "natural", or items 23 traumatic event, the Medical Examiner must 605 Mermaid Court 20657 United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 H No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Greenwell Grace Elizabeth Higgs 1 and 2 should b f Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Groft / Daughter 3243 Escapade Circle, Riva, Maryland 21140 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) St. John's Catholic Cemetery 10/18/2011 Hollywood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Neo Plasm - Lungs Sequentially list conditions, Examine Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 Other (specify) Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this of in by the funeral dire 1 ☐ Yes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours aft

To the Funeral Di

completed filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and D03077 October 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drw MD 135 West Dares Beach Road, Prince Frederick, MD 20678 Issam F. Damalouji, 31. Date filed (Month, Day, Year) 32. Registras Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#2016+operFH, 10/21/11; BMW, Moto Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:10am Wayne Morris. Sr. October 09,2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heartland Health Care Adelphi Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Months Davs Hours 64 578-25-6123 Director 11/30/1946 Guyana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 1 ☐Yes 2XINo Director Adelphi Maryland Prince George's 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1801 Metzerott Road 20783 Guyana Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 📉 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Construction 12 should be filed what and Mental Hygier 7 is marked other the or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Subil Muller Joseph Morris ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Easley St., #202, Silver Spring, Maryland 20910 Elaine Morris - Spouse Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Brentwood, Maryland Forenetzineen cenetery 1 XBurial 2 ☐ Cremation 3 ☐ Remova! from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven-Cem. 10/21/2011 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Respiratory Failure /Medical Due to (or as a consequence of): Examiner Metastatic Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Luc to for as a consequence of Examine certificate be executed Cardiac Arrythmia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical <u>Acute Renal Failure</u> IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 X No director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 🕱 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending Iniury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director;

Joannaletely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD52855 October 11,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Chandra Korapati,
31. Date filed (Month, Day, Year)

OCT 14 2011

32, Registrar's Signature

7207 Hanover Pkwy., Suite #B, Greenbelt, Maryland 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ OCTOBER 20<sup>rear</sup> 2:40  $P^{M}$ Angus William MacDonald Medical 4a. Facility Name (if not institution, give street and number) SOMERFORD 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WASHINGTON HAGERSTOWN ASSISTED LIVING & ALZHEIMER'S CARE 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** VIRGINIA 1 X M 2 🗆 F 04/27/1921 577-18-3789 90 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director 1 Yes 2 X No WASHINGTON HAGERSTOWN 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 23a Funeral UNITED STATES 10114 SHARPSBURG PIKE 21740 th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☑ Yes 2 ☐ No 1941—
If Yes, Give
Year or Dates. 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCKING MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Angus D. MacDonald Etta Pritchard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains 16639 SHEPHERDSTOWN PIKE, SHARPSBURG, MD Barbara Dante/ Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEAKE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 10/12/2011 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tre Funer FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: if yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica To Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1. Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 265 10112

DHMH 17 Rev 7/2009

Medicai

Campus Rel Ste. 107 Hogerstown no 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

£11110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34541 Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month 10 Physician/ 8:40 AM 2011 Margaret A. Martin Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Ceci1 Elkton Care and Rehabilitation E1kton Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Social Security Number **Funeral** Hours Months (Month, Day, Year) 4/16/1945 1 🗆 M 2 🕱 F England 66 Director 587-72-0981 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland **Funeral Director** notified 1 Yes 2 X No E1kton MD Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 0 s 23a o. r must b IISA 21921 One Price Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or iter Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ivy Winifred C.V. Claydon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once. 4021 Rosetree Lane Newark, DE 19702 Lee Martin - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/15/2011 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) R.T. Foard VFuneral . Home, cPA Rising Sun, MD 22. Name and Address of Facility R.T. Foard Funeral Home, PA 21. Signature of Funeral Servi 259 East Main Street, Elkton, MD 21921 23g. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Inset and Death Phy ician/ years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cormory Acting Disease. 23e. Did tobacco use contribute to the cause of death? Cormary Artery Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at eral Director: After filled in by the funer work?
1 \( \sum \) Yes 2 \( \sum \) No iniury 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of 🎾rtifie D0023322 10.13.2011 who completed cause of death (Item 23a) (Type, Prin ELKTON MD21921 126 A, E 31. Date filed (Monti

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34542 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1525 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci Elkton 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 - M 2 X F Hours Min. Country) **Director** MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil 1 🗆 Yes 2 💢 No 10e. Street and Number 10g. Citizen of What Country? Funeral 2004 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home makei 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miller husband 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) remotory 10/18/2011 Services 22. Name and ddress of Facility Strano + Feeley 635 Churchmans 21. Signature of Funeral Service Licenses Family I-uneval 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician, Posterior Reversible Encephaley atty Medical Examiner weeks. Hyperternion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine (or as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1xacheobranchits 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manyler of Death Certificate: 28b. Time of 28c. Injury at work? Natural 5 Pending Accident Suicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature d title of certifier grana 10/13/2011 D66176 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Bow Street, Elkton Vinay Sharma Mb Elkton Hosp.,

State Registrar 31. Date filed (Month, Day, Year)

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Day Marvel IVENU M 13 1422 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balhunc Randallstown Northwest Hospital If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 XF Days Hours 12/26/1928 Director 220-24-1987 82 MD Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No MD Baltimore Rockdale 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3419 Kimble Road 21244 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten Examiner 14. Race - American Indian Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give "natural" Specify. 3 Divorced Completed White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Librarian Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even ပ Silas Mallonee Ada G. Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Bayer - daughter 4185 Brittany Drive Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 10/18/2011 4 Donation 5 Other (Specify) Lakeview Cemetery Eldersburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death €hysician/ cardial arrest Medical resulting in death) Due to (or as a consequence of): Examiner ASCVO Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law equires that the death certificate be executed Cause (Disease or linjury Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day ed by the a detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de-23e. Did tobacco use contribute to the cause of death? ģ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate Yes 25 within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours after To the Funeral Direct City or Town, State) Medical 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D72317 October 13,2011 Name and address person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month)

Court

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MD

1 4 2011

old

egistrar's Signature

Read Randall Storm, MB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Z Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 24, 20 In Isabelle Naismith Morton 9:20 m Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Days Country Maryland Hours (Month Day 2 Year) 1919 Director 215-14-6355 Usual Residence of Decedent 28a-f show 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 No Maryland Allegany Lonaconing 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 57 Jackson Street 21539 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced 4 Divorced Specify: White Completed Year or Dates er than "natur the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Clothing 11 other Be 17. Father's Name (First, Middle, Last) f Health and Mental H item 27 is marked ot other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname, ပ James Stevenson Morton Annie Belle Frye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Timney - Nephew 20 Island Street, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. Page 1 Oak Hill Cemetery October 28. 1 Burial 2 Cremation 3 Removal from State Lonaconing, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovesculer infaction disease or condition Medical resulting in death) Examiner Generalizal 70 Years Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Petal death 3 Dectopic pregnancy
Pregnant at time of death 5 Dother (specify) in the past 12 months?

1 Yes 2 No Month Day signed by the a 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Prior Ceretovasculer infarction Records, 2 No 3 ☐ Probably 4 ☐ Unknown peen Pulmonar fibrosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Dementia of Alcheiner 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number D21488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Dogy las Ave., Long coning, md. 21539 Devlin 32. Registrar's Sign State Registrar

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia	an/	1. Decedent's Name (First, Middle, Last)			2. Date of Deat	h	V	3. Time of D	Death
	Medi	cal	William Everett Norman			Octobe	r <sup>Day</sup> 1	2011	4:40	Рм
	Examir	ner	4a. Facility Name (if not institution, give street and number)		Location of Death		4c. County			
	Funeral	_	9707 Old Georgetown Road #2419 5. Social Security Number   6. Sex   7. Age (In yrs. last birthday	Bethes  If Under 1 Year	da If Under 24 Hrs.	8. Date of Birth		tgome	ana Ctata av	Foreign
	Director		579-09-6722 1 M 2 □ F 97 Yrs.	Months Days	Hours Min.	Feb. II		Count	Virgi	nia
	of the state of th	Ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	anation						
	larylar <b>3a-f sl</b> ified a	Director	100. Oky, lown of L					10	d. Inside City 1  Yes :	
	the M or 28 e not		Maryland Montgomery Bethes  10e. Street and Number	10f. Zip Code			l0g. Citizen of \	What Count		2 140
:	if filed within 72 hours after death with the Maryland the Hygiene. All Hygiene. All Hygiene. All Hygiene. All Hygiene. All Hygiene went, the Medical Examiner must be notified at	Funeral	9707 Old Georgetown Road #2419	20814			U.S		.,-	
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen	cify Yes or No-		e - America		
39	al", or	d by	1 X Yes 2 No If Yes, Give	1 ☐ Yes 2 🗷 No		nour, occ.,	Specify.	k, White, e	ite	
Baltimore, Maryland 21215-0036	hours natura lical E	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupa	ation		16b. Kind of B			
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anc	ntal Herental Herenta	To B	17. Father's Name (First, Middle, Last)		18. Mother's Name			)		
<u> </u>	nd Me mark mark		Joseph Thomas Norman  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	Ning Address (Chrost		elle Wi				-
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Ball	permit. Page Department Important: I any injury or once.	1	mc and the	22. Name and Addres	•	DeVol 1				
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DI	h sioian/		Immediate Cause (Final	ter the mode of dying	g, such as cardiac of	respiratory arres	st,		Approximate Interval Betwe Onset and De	
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	. <u>.</u>	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							
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ou te be executed	sician	dical E	, , , , , , , , , , , , , , , , , , , ,							
oo/ou	h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	/ledi	d				,			=
certii	endin	an/N	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Live Birth 2 ☐ Fetal death 3	□ Estonia sussesses			23d. Dat	e of deliver	y	
<b>DOX</b>	he att	Physician/Me		Other (specify)	/		Moi	nth [	Day Yea	ar
that the	d by t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	on in Part I	Dog. Bidada				
v, v, ires t†	signe d be d	d by	Alzheimer's Disease	and onlying baddo give	or mer dire.	I	acco use contr s 2 🕱 No			- 1
e law requires	shoul	Completed				24a. Was an			y findings ava	
he la	te has	mo				autopsy perform	ned?	rior to com leath?	pletion of cau	ise of
VILCII I	ertifica ctor, p		25. Was case referred to medical examiner?	26. Pla	ce of Death (Check	1 \sum Yes 2	X No. 1	☐ Yes 2	<b>X</b> I No	
hysic	this ce	유	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other	r: 4  Nursing Hon	ne 5 🔀 Resider	nce 6 🗆 Othe	r (Specify)		
ding F	h. After 1 funera	Certificate:	27. Manner of Death  1   Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury	work?	1	3d. Describe hov	v injury occurre	d		
Atten	ctor:	ijĮ	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm st		∕es 2 □ No	06 1		D / C	In the Alexander	
								r or Hurai H	oute Number,	· [
lospit	t hour	edical	29a. Certifier  (Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time,	date and place, and	due to the caus	e(s) and manne	r as stated.		
the F	thin 24	∑ ļ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the	time, date and place	he time, date and and due to the c	place, and due ause(s) and ma	to the caus nner as stat	e(s) and mann ed.	er stated.
_ ₽	1 P S 1 M	1	29b. Signature and title of certifier	29c. License			d. Date signed			
	15+	-	30. Name and addless of person who completed cause of death (Item 23a) (Type,	> D552	258	C	ctober	13,	2011	
		ľ	Gary Wilks, MD, 7758 Wisconsin Aven	ue #211, E	Bethesda.	MD 2081	.4			
	State	~	31. Date filed (Month, Day, Year)	d.						
	Registra	r	OCT 14 2011 Leman B. Again							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 34546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 9, 2011 Physician/ Donald Eugene O'Dell, Sr. 5:30 Рм Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick 65 Adelina Road 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1**x** M 2 □ F 68 Hours JULY 15, 1943 MarvIand 216-40-9185 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. Counts be notified at 10a. State Director 1 Yes 2 XNo Prince Frederick MD Calvert 10f. Zip Code 10g. Citizen of What Country? 6 10e. Street and Number Funeral 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b United States 20678 65 Adelina Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction should be filed with h and Mental Hygien 7 is marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Carl Emmett O'Dell, Sr. Anna Mae Chaney 1 and 2 should be of Health and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Woodlow Ct. Huntingtown, MD 20639 19a. Informant's Name/Relationship (Type, Print) Donald E. O'Dell, Jr. - son injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Asbury Cemetery 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 10/13/2011 Barstow Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, PA 21. Signature of Funeral Service Licensee Draws 4405 Broomes Is. Rd. Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown signed by tall to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has the prior to completion of cause of death? performed Hospital or Attending Physician: The 2 No 1 Yes hin 24 hours after death.

the Funeral Director: After this certific

mpleted filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 I မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig October 10, 2011 leted cause of death (Item 23a) (Type, Print) 96m Hospital Road, Suite 310, Prince Frederick, Maryland 20678 MD 11Ŏ Eric Berg, 31. Date filed (Month, Day, 32. Registrar's Signature State 2 2/111 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death 8:59 Physician/ ay 201I October 7 Dovie Jane Plaster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Days Hours 1922 North Carolina **Director** 239-40-1765 Dec. 10. 1 □ M 2 □**X**F 88 Usual Residence of Dece 28a-f show 10d Inside City Limits 10c. City, Town or Location notified at Director 1 X Yes 2 No Prince George's Bowie Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ems 23a or must be r Funeral USA 20715 3925 Winchester Lane ian "natural", or items Medical Examiner mu hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed 16b. Kind of Business/Industry within 72 other than College (1-4 or 5+) Elementary/Secondary (0-12) Hygiene. the Healthcare Nursing/ Photo Processor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked o Jane Webb James Henry Hollander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 3925 Winchester Lane Bowie, MD 20715 Alice M. Plaster/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State te Concordenting Center place)
Methodist Church Cemetery 10/15/2011 X Burial 2 Cremation 3 Removal from State Catawba, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Se 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on eac Immediate Cause (Final aecuac Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Box 68760 IF FEMALE outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown P.O. | 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, the Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autops, performed 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending work?
1 Yes 2 No s after death. the Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a title of certifier 31. Date filed (Month, Day, Year) State OCT 1 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day RAYMOND O. PINION  $\mathbf{A}^{\mathsf{M}}$ OCTOBER 12, 2011 4:07 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 8. Date of Birth (Month, Day, Y SEPT 23, 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Year) 1927 **Funeral** Months Hours 1**X** M 2□ F Days 215-22-3329 MARYLAND Director 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examinar must be notified Director MARYLAND 1 Yes 2 □ No HARFORD **ABERDEEN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1003 WARWICK DRIVE, APT 1A 21001 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: BLACK 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN CITY GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Menta UNKNOWN DOROTHY PINION ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau DORIS DURBIN / SISTER 1003 WARWICK DRIVE, ABERDEEN, MARYLAND 21001 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State BERKLEY CEMETERY 10/19/11 4 ☐ Donation 5 ☐ Other (Specify) DARLINGTON, MARYLAND 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ling, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as IF FEMALE: nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknow ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 □Yes of Vital Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director; Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 29b. Signature and title 30. Name and addu 31. Date filed (Month, Day State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 10:15<sub>p</sub><sub>M</sub> Estela E. Quander Month 2011 October 9. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.

Months | Davs | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthdav. 9. Birthplace (State or Foreign Days Country 578-60-5460 Director 1 🗆 M 2 🕱 F 92Yrs. Dec. 15, 1918 Central America Usual Residence of Dec 28a-f shov the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Washington DC N/A 1 X Yes 2 No 10f. Zip Code 20020 10g. Citizen of What Country? 1859 Alabama Avenue, S.E. Funeral with Costa Rica death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Examiner Armed Forces?
1 ☐ Yes 2 ※ No ori þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1★ Yes 2 No Specify: Costa Rican Black If Yes, Give 3 

Widowed 4 □ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Catalina Caleb Angus unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Quander-Neverdon /daughter 245 33rd Street, N.E., Washington DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place or Department of Important If any injury or Suitland, Maryland Lincoln Memorial Cemi 10/15/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Failure to Thrive Physician/ Medical Due to (or as a consequence of **Examiner** Severe Dehydration Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury Dementia and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician as the bur Physician/Medical certificate be Box 68760 IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month Month Day Pregnant at time of death 1 ☐ Yes 238 detached the g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Urinary Tract Infection Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Electrolyte Inbalance 24a. Was an has page 2 performed? certificate Sacral Decubitus Ulcer or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 \( \text{Yes} 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred X Natural injury 5 Pending hours after death, Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) determined within 24 hours a To the Funeral D To the Hospital Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D0064100 October 10, 2011 MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State OCT 14 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ammend #5 SS# State of Maryland / Department of Health and Mental Hygiene CCHD-DW-10/19/2010 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20TT 5:40 October A M Edna Estelle Ridgely Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Asbury-Solomons Health Care Center Calvert Solomons Social Security Number 05–8884 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 01-29-1914 Days **Director** Washington. DC 97 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27: is marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notitied at 10a. State 10b. County 10d. Inside City Limits Director 10c. City, Town or Location 1 🗆 Yes 2 🕺 No MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11450 Asbury Circle, Apt. 330 20688 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🚺 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Key Punch Operator U. S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Dver Edith Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Beverly Ann Thompson - Daughter 11450 Asbury Circle, Apt. 231, Solomons, MD 20688 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 10-17-11 |Alexandria, Virginia 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Rausch Funeral Home, P. A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death n signed by the a ld be detached f 1 ☐ Yes 2 No 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown peen a Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? After this certificate funeral director, pag Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred iniurv 5 Pending work?
1 Yes 2 No eral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29c. License number 29d. Date signed (Month. Day, Year) D52242 October 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aru John Barth. MD III 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Slie Month Year ZOII Richar 10:15AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Min. 45 03/21/1966 Director 131-58-9180 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Huntingtown 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 3741 Hollyberry Drive 23a 20639 items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. or, þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. "natural", Completed Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) the Guidence Scretary of Health and Mental Hygien If item 27 is marked other the Ir other traumatic event, the Public School/Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard L. Dial Anna L. Bostic Important: If item 27 is n. any injury or other trees. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Dial - father 3741 Hollyberry Dr. Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/15/2011 1 X Burial 2 Cremation 3 Removal from State Port Republic Maryland 4 Donation 5 Other (Specify) Chesapeake Highland Memorial Garden 22. Name and Address of Facility Rausch Funeral Home Signature of Funeral Service Licenses 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading trained late cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy or Month Day Year Pregnant at time of death 5 Other (specify) should be detached 1 ☐ Yes 2 D 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No page 2 this certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **N** No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Il Director: After this of in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined within 24 hours a To the Funeral L Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ELLIS LEE ROBERSON OCT -2019 11 4:35 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GLADE VALLEY NURSING HOME WALKERSVILLE FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 | F Hours SEPT 28 **Director** 215-20-3265 83 1928 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD FREDERICK FREDERICK 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7098 CATALPA ROAD 21703 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Completed 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 in and Mental Hygiene.

7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12 MASTER PLUMBER PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM ROBERSON RUTH TOBERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is GWENDA ROBERSON/DAUGHTER 7098 CATALPA RD., FREDERICK, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or MONOCACY CEMETERY 10/15/201 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a) S. rvice 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) week Medical Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transi OFONO VOCIT that initiated events resulting in death) Last Due to (or as a consequence of by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? jo Day Year Pregnant at time of death Unknown should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 2 🗌 No Investigation 6 Could not be М Accident completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) KO50603 10-11-2011 ss of person who completed cause of death (Item 23a) (Type, Print) 6 Stoneridge Court Frederick (raupec RNP 6695

State

Registrar

31. Date filed (Month, Day, Year)

OCT

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:32A M RIFFE CARL FRANK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Cumberland Western MD Regional Medical Center . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 □ F Months Hours Nov. 27, 1934 Director 235-52-7804 76 Welch, Usual Residence of Decedent 28a-f show Ħ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified WV Mineral 1 X Yes 2 No Keyser 10e. Street and Numbe 10f. Zip Code ö 10g, Citizen of What Country? items 23a Funeral 575 Baltimore Street, Apt. 2-L 26726 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. ō à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 X Divorced Specify: White Year or Dates. 1957-66 Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the College Custodian should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Menta Important: If frem 27 is marked to any injury or other traumations. ည Frank George Riffe Dortha Mae Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26726 William E. Riffe/Grandson 575 Baltimore Street, Apt. 2-L Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Oct. 4 Donation 5 Other (Specify) Beahm's Chapel Cemetery 2011 Luray, Virginia 22. Name and Address of Facility Smith Funeral Home 21. Signature of Funeral Service Line 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g 🔲 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 Yes 2 No 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 20 NO Certificate: To 1 Yes Other: 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and certifie 10,19,11

Registrar
DHMH 17 Rev 7/2009

State

P.O. Box 539

21502

Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Ardalan Enkeshafi,

11-07848 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William E Rafferty State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) Rea No 2. Date of Death Physician/ Month Day October 19, 2011 **Medical Examiner** William Edward Rafferty 0522 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Country) WI Davs Director 236-90-0004 Sept. 23,2011 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County Hagerstown 1 X Yes 2 No marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17667 Gettysburg Way 21740 USA Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes Specify: White 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 President Paving Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William Edward Rafferty Julia Ann Doughterty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Rafferty/ Wife 17667 Gettysburg Way, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State woodlawn Cemetery Oct. 25, 2011 Gotha, Florida 4 Donation 5 Other Specify 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Physician /Medical Examiner Physician/Medical Examiner attending physician and or use as the burial - transit

Division of Vital Records, P.O. Box 68760. After this certificate has been subneral director, page 2 should

Completed by

Medical Certification: To Be

State Registrar

29b. Signature and title of certifier

Laron Locke MD.

31. Date filed (Month, Day, Year) 0CT 2 8 2011

be

ne and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

	ine	1331 Easte	ern Blvd.	N., Hagerstown,	MD 21742
23a. Part I, Enter the disease or complications that failure. List only one cause on each line.		nter the mode of dying,	such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and
	ne and Alcoho	l Intoxica	tion		Death
or condition resulting in death)  Due to (or as	s a consequence of):				
Sequentially list conditions, b					
if any, leading to immediate Due to (or a cause. Enter Underlying Cause	s a consequence of);				
(Disease or injury that initiated C.					
events resulting in death) Last	s a consequence of):				
d					
UNPENDED AMENDE	23a,27,28a-f	per me,g9	21 11–16–	-ll sm	
IF FEMALE: 23c. If ye	s, outcome of pregnancy			23d. Date of delive	erv
23b. Was decedent pregnant in the past 12 months?	e birth	Fetal death 3	Ectopic pregnane	icy Month	Day Year
4 Pre	gnant at time of death 5	Other (Specify)			
1 Yes 2 No 9 Unknown 9 Unknown	known				
Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause of	iven in Part I.	23e. Did tobacco use contribute t	o the cause of death?
				1 Yes 2 No 3 Pr	obably 4 🗹 Unknown
					autopsy findings available
				autopsy prior to performed? death?	completion of cause of
					res 2 No
25. Was case referred to medical		26.Place	of Death (Check on	nly one)	
examiner?	Inpatient 2 ✓ ER/Outpa		Othor -	Home 5 Residence 6 Oth	0.5
1 Yes 2 No					er.
(Mor	te of Injury 28b. Time			28d. Describe how injury occurred	
Natural 5 Pending Pending Investigation	10-19-11 fd 4:	20 am 1 1	res 2 🗶 No 🛮 1	unknown	
28e Pl	ace of Injury - At home, farm,	street, factory, office b	uilding, etc. 2	28f. Location (Street and Number or F	tural Route Number, City
3 Suicide 6 X Could not be determined (Specif	Found:	in motel r		or Town, State)Motel 61: Blvd. Hagerstown	1321 Massey
29a. Certifier 1 CertifyIng Physician: To the b	est of my knowledge, death of	occurred at the time, da	ite and place, and di	lue to the cause(s) and manner as sta	ated.
one) 2 Medical Examiner:On the basi					

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 20, 2011

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Z:50 PM Jean Smith Norma Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Agnes Hospital SALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 🌠 F 0777971925 MarvIand Director 220-12-0907 86 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number by Funeral U.S.A. 21228 707 Maiden Choice Lane, Apt 8T05 or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 🗓 No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white Hygiene. other than "natural", If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) electric company secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Timmons Helena Rogers John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 .. Page 1 and 2 st tment of Health a tant: If item 27 is 707 Maiden Choice Ln., Apt 8T05, Catonsville, MD Smith, husband Walter Hagan Important: If item any injury 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James Parish 10/13/2011 Lothian, MD Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Sepsil Physician/ disease or condition resulting in death) day Medical Due to (or as a consequence of): Examiner ectosigmoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknowr Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending injury work? 1 Natural Accident 2 No Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Hornicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 29b. Signature and 29d. Date signed (Month, Day, Year) P25907 0 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW CATIN AVE BALTIMORE. JOHN GLUFFREDA 07) 31. Date filed (Month, Day, Year) 32. Registra Signature State

Registrar

OCT

11-07555 Su

-07555		Please Type or Print in Black Indel		
ng Yong Suh	1	State of Maryland / Departm 1- For State Certification	ent of Health and Mental H eate of Death	ygiene Reg. No. 2011 345
Physic edical Exam		Decedent's Name (First, Middle,Last)     Sungyong Suh     4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	
Funeral Director		Shady Grove Adventist  5. Social Security Number  6. Sex  7. Age (In yrs. last birt)  219-13-5427  1 X M 2 F 87	thday)   If Under 1 Year   If Under 24Hrs   Months   Days   Hours   Min	1
Maryland 28a-f show any d at ooce.	tor	Usual Residence of Decedent  10a. State		10d. Inside City Lim  1 X Yes 2 1  10g. Citizen of What Country?
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygiene and Chealth and Montal Hygiene of the state of the action 23s or 28s-f sho or other traumatic evect, the Medical Examiner must be sotified at occ.	Funeral Director	17060 King James Way  11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No	20877  13. Was Decedent of Hispanic Origin? ( Single Yes, specify Cuban, Mexican, Puerto	
16 n 72 hours after . seo "oatural", o	Completed by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	1 Yes 2 XX No specify:  Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	ired)
ore, MD 21215-0036 of sel and 2 should be filed within 72 hours after the filed than 14 spiene. If item 27 is marked other than "outural", ther traumatic eveot, the Medical Examiner.	o Be Comp	17. Father's Name (First, Middle, Last) Kooha Suh	Hee Choi	Police Department e (First, Middle, Maiden Surname) L Rural Route Number, City or Town, State, Zip Code)
iore, MD 2 ges 1 and 2 shou at of Health and N : If item 27 is n other traumatic	7	Yong Suh - Son  20a. Method of Disposition 1 X Buriel 2 Cremation 3 X Removal from State cremat	7342 Heatherhill Court, of Disposition (Name of cemetery, tory or other place)	Bethesda, MD 20817  Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee  Aug. 1477  A	22. Name and Address of Facility National Funeral Home,	715/2011 Falls Church, Virgini 7482 Lee Hwy, Falls Church, VA 220 or respiratory arrest, shock, or heart Approximate Inter
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Immediate Cause (Final disease on each line.  Exanguination Complicating Due to (or as a consequence of):  End Stage Renal Disease  Due to (or as a consequence of):  Hypertensive Atherosclerotic	Dialysis  c Cardiovascular Disease & Diabo	Between Onset a Death
be executed sician and turial - transit	dical Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  UNPENDED  AMENDED		
Box 68760, e death certificate be ex the attending physician ed for use as the burial -	Physician/Medi	past 12 months?	2 Fetal death 3 Ectopic pregn. 5 Other (Specify)	ancy Month Day Year
cords, P.O. Bilaw requires that the de has been signed by the 2 should be detached for	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknow  24a. Was an 24b. Were autopsy findings availa prior to completion of cause
Vital Reconysiciae: The law this certificate has I director, page 2 si	be Completed	25. Was case referred to medical examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/O	26.Place of Death (Check	performed? 1 Yes 2 No 1 Yes 2 No
I of Hog P After funera	Certification: To	27. Manner of Death    Value   State   Pending   28a. Date of Injury (Month, Day, Year)   28b.	Time of Injury 28c. Injury at Work?  1 Yes 2 No arm, street, factory, office building, etc.	28d. Describe how injury occurred  dialysis catheter broke  28f. Location (Street and Number or Rural Route Number, Control State) 17060. King Lamps 1
Division  To the Hospital or Attent within 24 hours after death To the Fuocral Director: completely filled in by the	Medical Cerl	4 Homicide determined (Specify) residence  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	eath occurred at the time, date and place, and	
	W	29b Signature and title of certifiery  29b Signature and title of certifiery  29b Signature and title of certifiery  30. Name and address of person who completed cause of death (Item 23a)	29c. License number O. C.M.E.	29d. Date signed (Month, Day, Year) October 9, 2011
2	tate	24 Date filed (Month Day Vend) 22 Penjetrade Signature	900 W. Baltimore Street, Baltimo	ore, MD 21223
Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature	parled.	

DHMH 17 Rev 1/2001 OCME 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma	aryland / Dep <i>Ce</i>	partment of H artificate of D			giene Reg. No. 20		34557
П	Physicia	m/	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Date of Death     3. Time of Death					
	Medic Examin	al	Ruth Ellen 4a. Facility Name (if not institution, give street and number)	Skolnick		Month ber 12, 2011  or Location of Death  dec. County of Death				2:48 рм
-4	Examin	ier	405 Maravista Court		2.	r Spring		4c. County		tgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age 117-32-4599 1 M 2 🛱 F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthpl Count	olace (State or Foreign try)
Go.			Usual Residence of Decedent	69 Yrs.			11/29	/1941		ew York
	uyland a-f sho ied at	Director	10a. State 10b. County	10c. City, Town or L		Puch Con	ina		10	0d. Inside City Limits 1 ☐ Yes 2 🛛 No
	the Ma or 28a e notif	Dire	Maryland   Montgomery   10e. Street and Number		10f. Zip Code	lver Spr	zng T	10g. Citizen of V	Vhat Coun	
	h with ns 23a must b	Funeral	405 Maravista Court			20905			u.s.	. A <b>.</b>
(0	er deat or iten niner u	by Fu	11. Marital Status  12. Was Decedent E  Armed Forces?  1 □ Never Married 2 🏿 Married  12. Was Decedent E  Armed Forces?  1 □ Yes 2 🖔	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
003	urs aftu :ural", al Exar		3 Widowed 4 Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify:	W	rite
21215-0036	72 ho In "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupat kind of work done du DO NOT use retired)		ing	16b. Kind of Bu	siness/Ind	lustry
212	within /giene. ner tha t, the f		Elementary/Secondary (0-12) College (1-4 or 5	(+)	Legal As	sistant			Lo	aw
Maryland	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last)  Eugene Wital			18. Mother's Nam		Maiden Surname riet Agi		
aryl	hould I	75	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street ar	nd Number or Rura				code)
	and 2 s lealth a		Fred R. Skolnick - Spouse	_						land 20905
nore	age 1 sent of H		20a. Method of Disposition  1 □X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place, Remembra	)	Date 6 / 2 0 1 1	20c. Location -	,	
Baltimore,	epartmo spartmo sportar sy injur	133	21. Signature of Funeral Service Licensee							Home, Inc.
m	e a i i i	(1)	Kalnina Luguese	nu 1					<u>Sprin</u>	g, MD 20904
. 175 m	Ph_sician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final		ter the mode of dying,	, such as cardiac (	or respiratory arr	est,		Approximate Interval Between Onset and Death Months
	Medical Examiner			Cancer consequence of):					1	1 Months
	Exammer	er	Sequentially list conditions, b.	ใ จับกล้อนุนอกจ้อ <i>บก</i> ู้:					_	
	d d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	odnasquenos oij.						
	icate be executed in physician and its the burial transit			a consequence of):						
760	death certificate be executed ne attending physician and ed for use as the burial transi	ledical	d							
× 68	h certif tending ir use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth	of pregnancy 2  Fetal death 3	Ectopic pregnancy				e of delive	
Box	r the att	ıysici	in the past 12 months?  1  Yes 2 No 9  Unknown	t time of death 5	Other (specify)			Mor	nth	Day Year
J.	law requires that the death certific nas been signed by the attending e 2 should be detached for use as	by Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the	underlying cause give	n in Part I.	23e. Did to	bacco use contr	ibute to the	e cause of death?
rds,	equires een sig nould b						1 🗆 `			pably 4 🗆 Unknown
Vital Records,	e law r e ha <b>s</b> b ige 2 sl	Completed					24a. Was autop	rmed?	rior to con leath?	osy findings available mpletion of cause of
e E	sician: The law is certificate has k		25. Was case referred to medical examiner?		26. Plac	ce of Death (Check	1 \(\superset \text{Yes}\)	2 <b>X</b> No 1	☐ Yes	2 □ No
-	Phy this	은	1 ☐ Yes 2 🕱 No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie		4 L Nursing Ho		lence 6 🗆 Othe		
o uc	nding ath.	icate	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	y 28b. Time o injury	work?		28d, Describe h	ow injury occurre	d	
DIVISION OF	or Atter frer des irector n by th	Certificate:	3 Suicide 6 Could not be	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural	Route Number,
5	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifler 1 Certifying Physician: To the best of r		occurred at the time.	date and place, a	nd due to the ca	use(s) and mann	er as state	ed.
	the Hos iin 24 h he Fur ipletely	Medical	(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practitioner: To the	camination and/or inves	stigation, in my opinion	, death occurred at	the time, date a	nd place, and due	to the cau	use(s) and manner stated.
	To with		29b. Signature and title of certifier	ch.	29c. License r			29d. Date signed		
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type.		R162370		UCLOB	et 1:	3, 2011
			Michelle M. Turner, CRNP,	22 S. Gree	ene Street	, Baltim	ore, Ma	ryland 2	1201	
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 14 2011	r's Signature	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34558 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:10 AM <sub>M</sub> 2. Date of Death 10 Physician/ Harry Shaw, Jr. Day13 2041 Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkton Care & Rehabilitation Center E1kton Cecil Age (In yrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Sex 1X M 2 □ F 8. Date of Birth 220-03-0598 Months Days Hours Min JUME, DIOYO 1922 Mary Yand Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director DE New Castle New Castle 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Parker Place 19720 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. White Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify. 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Machine Shop Foreman Elementary/Seconday (0-12) 2 College (1-4 or 5+) Mechanical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Lee Shaw Mary Hester Traverse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Shaw 1320 Maryland Avenue, Wilmington, DE 19805 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10-14-11 4 ☐ Donation 5 ☐ Other (Specify) Brandywine Valley Wilmington, DE 19809 Funeral Service Licenses 22. Name and Address of Facility Yasik Funeral Home Stanley S. Old Capital Trail, Newark, DE 19711 a warm. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which is cardiac or respiratory arrest, and on the respiratory arrest, and on the respiratory arrest, and the respiratory arrest a Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CVA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🗷 No Day Year Pregnant at time of death signed by the a Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DM Completed 1 Yes 2 No 3 Probably 4 Unknown should peen HTN Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Dementia 1 Yes 2 No Yes 2. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending injury 24 hours after death. Funeral Director; A 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature 29c. License number D0062190 10/13/2011 Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

2533 Augustine Herman Highway, Suite A, Chesapeake City, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shahnawaz Khan, MD

21915

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21,22 per hosp. *Certificate of Death* amend 15,1621,22 per hosp. Decedent's Name (First, Middle, Last) 2. Date of Death Month 200 Physician/ Medical give street and number) 4b. City Town, or Location of Death **Examiner** nna 160 Birthplace (State or Foreign Country) If Under Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Yrs Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21035 Funeral WERNO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates hite 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Infant 0 Infant 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rural Route Number, City John City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Location - City or Town, State Date 20b. Place of Disposition (Name of . Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mod 5 Other (Specify) 4 Donation 22. Name and Address of Facility Signature of Funeral Service Licensee 21401 Anne Arundel Med. Center Paul Weisburger, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final √Physician/ OMIO Keme disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown the g Unknown P.O. ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be de 2 No 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? certificate has performed Yes 2 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 28d. Describe how injury occurred filled in by the funeral Date of injury 27. Manner of Death 28a 28c. Injury at (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural Accident 5 Pending death. М Investigation 24 hours after deatle Funeral Director: Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2 Print) pleted cause of death (Item 23a) (Type, Registrar's Sign State Registrar

DHMH 17 Rev 7/2009

11-07878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Angelina Sharo	n	State of 1- For State Registrar	Maryland / Depa	artment of ertificate of		Mental I		eg. No. 201	1 31.56
Physic Medical Exam	ian/ ine	Decedent's Name (First, Middle,Last)     Angelina	Marie	Sharon	-		2. Date of Deat Month October 20	h Day Year	3. Time of Death 0017 hrs
		4a. Facility Name (if not institution, give st Western Maryland Health Sy	reet and number)		. City, Town, or Location of Death Comberland Allegany				
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of Birt	th(MM/DD/YYYY) 9. Bir	thplace (State or
Director		000 17 7 100	2 x F 0	Yrs.	Months Days	Hours Mi	Oct 4.	2011 Foreig	in untryMD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locatio	n				10d. Inside City Limits
/land -f show	호	MD Allega	ny	Cum	berland				1 X Yes 2 No
ith the Maryland 23s or 28s-f sho notified at once	Director	10e. Street and Number 542 Greene Stree	t		10f. Zip Code	21502	1	og. Citizen of What Cour	-
h with tems 23s	Funeral		. Was Decedent Ever in U Armed Forces?		Decedent of Hispa s, specify Cuban, N	nic Origin? ( 8	specify Yes or No-		
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she sal.Et miner must be notified at once		3 Widowed 4 Divorced If Y	Yes 2 X No		res 2 √ No s		o Rican, etc.)	Specify: Whi	te
hours a	ed by	15. Decedent's Education (Specify only h		16a. Decedent's	Usual Occupation	n (Give kind of		16b. Kind of Business/I	
036 thin 72 ne. r than " fedical.]	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	infant			,	I	
21215-0036 nuld be filed within 72 hou Mental Hygiene. marked other than "nan ic event, the Medical Ex		17. Father's Name (First, Middle, Last)		ı—ınıanı	18.	.Mother's Nam	e (First, Middle, M	n/a laiden Surname)	
2121 ould be fi d Mental s marked	To Be	Michael T Shai 19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street a	Mor	gan P. G ural Route Numl	rubb ber, City or Town, State,	Zip Code)
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		Diane Wagus  20a. Method of Disposition	grandmoth		LaFayett		ue Cu	mberland	MD 21502
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other tr		1 X Burial 2 Cremation 3 1	Removal from State	crematory or othe	r place)	lery,		20c. Location - City or	
Baltir permit. I Departme Importal		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	Sur	nset Memo 22. Na	me and Address of		10/24/201	Cumberla	and MD
Physician		23a. Part . Enter the disease, or complicat	ons that caused the death.	. Do not enter the			Home, PA	dayid MD 21502	Approximate Interval
/Medical		failufe. List only one cause on each li Immediate Cause (Final disease a.Su	<sup>ne.</sup> Iden Unexpla						Between Onset and Death
<i>f</i>		or condition resulting in death)  Due  Sequentially list conditions,  b.	to (or as a consequence of	f):					
	iner	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of	f):		•			
ecuted and - transit	Examiner	overno resulting in seattly East	to (or as a consequence of	f):					
Division of Vital Records, P.O. Box 68760, 24 hours after death certificate be executed 24 hours after death.  Puneral Director: After this certificate has been signed by the attending physician and eath fine this certificate has been signed by the attending physician and eaty filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	edical	d d AN	MENDED 23a,27,2	28a-f,pe	r me,g923	3 1-9-1	2 sm	<u></u>	
8760 ificate b ig physics of the bu	n/Me	23b. Was decedent pregnant in the	Sc. If yes, outcome of pregr		death 3	Ectopic pregna		23d. Date of delivery	
OX 6876 eath certificate s attending phy for use as the l	sician/N	past 12 months?	Pregnant at time of dea	ath _	(Specify)	Ectopic pregna		Month D	ay Year
O. B. at the de tached f	/ Physic		Unknown ributing to death but not re	esulting in the unc	er!ying cause give	n in Part I.	23e. Did tob	accc use contribute to t	ne cause of death?
S, P.(	ed by							2 No 3 Proba	ably 4 🗹 Unknown
Cord	Completed						24a. Was ar autopsy perform	y prior to co	opsy findings available ompletion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical			26.Place of	Death (Check	1 ✔ Yes 2		2 No
F Vit;	To Be	examiner? 1 Yes 2 No 27. Menner of Death	I Inpatient 2				ng Home 5 R		
ion o trending eath. tor: After the fune	tion:	1 Natural 5 Pending	Rea. Date of Injury (Month, Day, Year)  fd 10-19-11	28b. Time of Inju		t Work?	28d. Describe ho unknown	ow injury occurred	
lvisi I or Att after de Directe	Certification:	Suicide Suicide Could not be	28e. Place of Injury - At ho		•	ling, etc.		reet and Number or Run	
Divisio  To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:									
To the within To the complex	Medical	one) 2 Medical Examiner:On t			, in my opinion, de	ath occurred a			
	2	29b. Signature and title of certifier	00 11		29c. License nu O.C.M.E			29d. Date signed (Mont October 20, 2011	h, Day, Year)
	ŀ	30. Name and address of person who compl							
Şt.	ate		edical Examiner 9		ore Street, Ba	altimore, M	D 21223		
Regist	rar	OCT 28 2011	32. Registra s Signelly	-					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name *(First, Middle, Last)* Loretta C 2. Date of Death 3. Time of Death Thomas Physician/ Month Day Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4725 Brookfield Drive Suitland Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept. 15, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 🗆 M 2🏋 F 212-42-6755 **Director** 70 Sept. 1941 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MDPrince George's 1 Yes 2 No Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4725 Brookfield Drive 20746 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muss once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 XDivorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 D.C. Public Schools College (1-4 or 5+) Food Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin William Young Virginia Evelyn Willett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3706~Dunlap~St.~Temple~Hills,~MD~20Wanda Ashe/daughter Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Metro. Crematory 10/11/2011 Alexandria, 22. Name and Address of Facility Sewell Funeral Home, 21. Signature of Funeral Service Licensee 1451 Dares Beach Rd. Prince Fred..MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Metastatic Liver Cancer Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 Yes 2 ANo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 5 Pending iniury Division Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Stilleams DO H0058032 10/10/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JRW

State Registrar

31. Date filed (Month, Day, Year)

Cynthia M. Williams, 32. Registrar Signature

Calverton, MD 20705

DHMH 17 Rev 7/2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCTOBER 8:32A HAZAEL GILREATH TAYLOR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 🗆 M 2 🕱 F Nov. 16, 1920 South Carolina **Director** 242-36-9170 90 Usual Residence of Decedent show at 10a. State 10h County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7406 Hillside Drive 21702 United States items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No If Yes, Give Black White etc. o. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ the College Professor Higher Education traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. ပ John S. Taylor Hazael Gilreath t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Neuman / Friend 7406 Hillside Dr., Frederick, MD 21702 Oct. 2011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State T2, permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 21. Signature of Fu Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23 Fart 1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (presideor sequence of) The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant s, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? Day Month Year signed by the Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? PX No ည 1 Inpatient 2 I ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 23a) (Type, Print) Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State	State of Ma	aryland / Dep	artment of H rtificate of I			ZUII	34563
			Registrar  1. Decedent's Name (First, Middle, Las	st)		rimoute or i	Journ	2. Date of Death	g. No.	3. Time of Death
	Physici	an		aylor				Month	Day Year	11:15 p M
	/Medic					4h Cih, Tours o	Location of Death	October	4c. County of Dear	
	Examin	er	4a. Facility Name (If not institution, give							
			Woodside Genesis			+	Spring If Under 24 Hrs.	2 Data of Righ	Montgo	
	Funeral		5. Social Security Number 6. Social Security Number 1	ex 7.Age KDM 2□F	(In yrs. last birthday,	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent		91 Yrs.			Sept. 27	, 1920	NY
	and *	}	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	sho	5								1 □ Yes 2 🛣 No
	he N	Director	MD Mont	gomery	Silve	r Spring		10	og. Citizen of What Co	number 2
	with or s	吉					_		-	outing:
	s 23	Funeral	10101 Portland			2090			USA	dana ladina
	er de	nue	11. Marital Status	12. Was Decedent I Amed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 1	10	1 ☐ Yes 🟂 ☐ No	Specify:		Specify: Wh	ite
8	hour ural	d b		Year or Dates:		1		1.	ICh Kind of Business	/Industry
5	"nel	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	edent's Usual Occup e kind of work done OO NOT use retired	ation during most of work	ting '	16b. Kind of Business	industry
2	within and the standard standa	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)	reman	,		Law Enfo	roomont
2	lled Hygie her nt, II		17. Father's Name (First, Middle, Last)		1.1	.reman	18 Mother's Nam	e (First, Middle, M		rcement
aryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Items 23a or 28a-f show aumatic event, the Medical Expraner must be notified at	Be	Thomas Taylor					n Glennoi		
ž	es 1 and 2 should b of Health and Ments fitem 27 is marked r other traumatic e	ဥ								7. 0
a S	2 st and and is in		19a. Informant's Name/Relationship (7						City or Town, State,	
	and lealth m 27 har t		Muriel Zakas/Daug	hter,	1010	l Portlan			ring, MD	
0	of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☼ premation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of Imatory or other plac	n (a	Date 2	20c. Location - City or	Town, State
Ε	Pages ment of I ant: If its ury or o		* 4 □ Donation / 5 □ Other Specify	0	Metropoli	Ltan Crema		2011 ' A	Alexandria	, VA
Baltimore,	permit. Pages Depertment of the Important: If ite any injury or of once.		21. Signature / Fineral Strvice Ucen	se	2 F	2. Name and Addre	ss of Facility	Funeral	Home Inc.	
<b></b>	20 E 2 9		May .	11	5	00 Univer	sity Blv	1. W., SI	llver Spri	ne. MD 20901
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused	the death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		tic Lung	Canaar				Onset and Death months
	/Medical		resulting in death)	Maria and and and and and and and and and an	a consequence of):	cancer				MOHENS
	Examiner			Gastroi	ntestinal	Bleeding				nouths
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	uted a same	Examiner	If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć.	n an iatr	Exa	resulting in death) Last	Due to (or as	a consequence of):					
8760,	licate be executed physician and sthe burial transit	dical		d =====						
89	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial transit	edic		. 4.						
X	eath certifi attending   for use as	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d. Date of de	alivery
Вох	eath atte	clai	in the past 12 months?	1∐Live birth 4∐Pregnant at		□Ectopic pregnancy □ Other <i>(specify)</i> _	<b>,</b>		Month	Day Year
o.	at the de by the a tached	ıys	1  Yes 2 No	9□ Unknown		_ ,, ,, _,				
₾.	res that igned b be deta	Completed by Physician/M	Part II. Other significant conditions c	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute i	to the cause of death?
Records,	sign d be	d b	Anemia, Dementia					4€ Ye	s 2 No 3 F	robably 4 DUnknown
Ö	w require been sig should b	ete			***			04-146	0.45 14/200	ustantas findinas avadabla
ec	e law has	Пр						24a. Was ai autops perforn	y prior to	utopsy findings available completion of cause of
	: The l cate ha	Ö						1 ☐ Yes 2		s 2 No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Manager				th (Check only on	e)	
<u></u>	Physi this c	ို	1 ☐ Yes 2 本 No	Hospital: 1 ☐ Inpatie			4 (23 14 u 15 i 1 i g 1 i		ence 6 Other (Sp.	ecify)
Division of	ttending P death. stor: After t	Certification:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Dat	ry 28b. Time ( y Year) Injury	Wor	k?	28d. Describe ho	ow injury occurred	
Sio	eath.	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No			
Ξ	pr Ati	Ħ	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rurai Route Number,
Ω	itel c	Se								
	Hosp 4 hou Fune ely fil	ical	(Check only 2 Medical Exam	nysician: To the best niner: On the basis of	f examination and/or i	th occurred at the tir	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	as stated. as to the cause(s)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	one)	and manner sta	ated.					
	2 1 P	Fy	29b. Signature and title of certifier	11	) 116	29c. Licens	e (1001109)	2	9d. Date signed (Mor	nn, Day, 1841)
	10	7	1	-04		D6	8583		October	13, 2011
			30. Name and address of person who							
			Tanyech Walford	·	9101 Secon		, Silver	Spring,	MD 20910	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	whit.				
	Registi	ar	OCT 14 201	1 / Louis	J B. 19"					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend#24a, per Dr., QACHD, ms, 10/13/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLES EMANUEL THOMAS OCTOBER 20 I T 4:04 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death THE HEARTLAND HOUSE, INC. QUEEN ANNE'S GRASONVILLE . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours Months 0472771916 95 NEW YORK Director 577-10-9484 Yrs. Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD 1 Yes 2X No QUEEN ANNE'S STEVENSVILLE 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a hours after death with 100 MARYLAND AVENUE 21666 UNITED STATES items 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: WHITE Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 than INTERNAL REVENUE Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withindrent of Health and Mental Hygien rrant: If item 27 is marked other tholury or other traumatic event, the IRS INVESTIGATOR SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GEORGE THOMAS CARRIE BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 21 any injury or other to once. JUDITH STRAWSER / DAUGHTER 100 MARYLAND AVENUE, STEVENSVILLE, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State FORT LINCOLN CEMETERY 10/15/2011 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MD 21. Signature of Funeral 3. ice License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ to THUS'VE Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NOFOUNd Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine executed enile and burial-tran Due to (or as a consequence of) resulting in death) Last igned by the attending physician be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 No 1 Yes' 2X burs after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: မ 6 Pother (Specify) CARE HOHE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred **■** Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 23889 e of death (Item 23a) (Type, Print) Street, CHEStantown, Wed 21420 ATZIZABA 223

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34565 State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 600 Terry Von Taylor Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Feb. 1, 1961 Days Hours Months 1 X M 2 □ Keyser, WV 50 232-98-6172 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Yes 2 No WW Mineral Burlington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 , or items 23a Funeral USA 26710 Rt. 1, Box 212 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married \$ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) General Labor Handyman permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williamina Josephine Stieringer Brady Russell Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rt. 1, Box 212 Burlington, WV James H. Taylor/ Brother Oct. 22, 20 120c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗌 Removal from State Smith Funeral Home Crematory Keyser, WV 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of June al Service Licensee Smith Funeral Home et Keyser, WV 26726 85 S. Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anoxic encephalopathy disease or condition resulting in death) Medical 4 days Examiner Aspiration Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 4 days burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last ending physician are use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been sinned by the attending hours. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day for 5 Other (specify) Pregnant at time of death s been signed by the s should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pneumonia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has page 2 s performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Be 2 🗌 No Other: Yes Yes 🖊 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Ye 10/12/11 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Year) 1:20P M 1 Natural 5 Pending þt aspirated 1 Yes 2 No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de

To the Funeral Directo

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Knobley store Keyser W Va store the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Destriying Prinstream. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Prinstream of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Prinstream of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/19/11

State Registrar Paul

31. Date filed (Month, Day, Year)

) gwi

arks

24 W 3rd St Cumberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Snow M.D

2 8 2011

09157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Jane Ellen Vogle 2011 3:10 AM Medical Oct 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Genesis HealthCare -The Pines Easton 5. Social Security Number Birthplace (State or Foreign Country) Year If Under 24 Hrs. Funeral . Age (In yrs. last birthdav) If Under 1 8. Date of Birth Hours (Month, Day, Year) 1 □ M 2 🔀 F Months 214-14-7341 **Director** 89 1921 Dec Virgini Usual Residence of Decedent 28a-f show 10a State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Medical Examiner must be notified at Director MD 1 XYes 2 ☐ No Talbot Easton 10g. Citizen of What Country? 5 10e. Street and Numbe 10f. Zip Code 23a Funeral 303 South Aurora Street 21601 United States "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Jane Vogle Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Earl Frederick Mary Jane Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Darcy Bernot/Daughter 303 S. Aurora St., Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/24/2011 Cambridge, Maryland Mid-Shore Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home Muhael 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 5ep515 Physician disease or condition resulting in death) **Medical** Due to (or as a consequence of): Examiner 20Ke MATEREXS Sequentially list conditions Examine cause. Enter Underlying ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month 5 Other (specify) Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🔲 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 508 Registrar's Signati EASTON.

11-07831 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Marcus Lavonn Wicks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day October 18, 2011 Medical Examiner La'Von Wicks 1337 hrs Marcus 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester River Hopital Chestertown Kent 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days oreign Country Hours 214-91-0410 1 M 2 F 05 05/05/2011 Usual Residence of Decedent 20, 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show MD Kent Millington 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a.f. sho 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Baltimore, MD 21215-0036 Physician /Medica

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brouns after death.

To the Functal Director: After this certificate has been signed by the attending physician and completely filled in 99 the functal physician and completely filled in 99 the functal page 2 should be detached for use as the burial - transit completely filled in 99 the functal director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

Ö	157 Millington RD	21651	USA	USA					
Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>		ican Indian, Black,					
	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		,						
ھ	or Dates:	1 Yes 2 No specify:		ck/White					
e l	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
	Elementary/Secondary (0-12) College (1-4 or 5+)								
6	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   16b. Kind of Business/Industry during most of working life. DO NOT use retired)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)								
88									
100									
1-	Margaret M. Rega/Mother 19	9055 Stedwick Dr.	. Montgomery Vil	lage. MD					
	20a. Method of Disposition 20b. Place of	f Disposition (Name of cemetery,	Date 20c. Location - City or						
	4 to D 1 O O O O O O O O O O O O O O O O O	ory or other place) Souls Cemetery 10							
	4 Donation 5 Other Specify:	Later and the second se	Z0/11 GCIMAIICO	W11 <b>/</b> 11B					
	21. Signature of Funeral Service		ennie Smith Fune						
-	23a. Part I. Enter the disease, or complications that caused the death. Do not	1855 High ST Che	estertown, MD 21						
1	failure. List only one cause on each line.	tenter the mode or dying, such as cardiac o	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and					
	Immediate Cause (Final disease or condition resulting in death)	l Death In Infancy		Death					
	Due to (or as a consequence or).								
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
튙	cause. Enter Underlying Cause (Disease or injury that initiated			ļ					
Examiner	events resulting in death) Last Due to (or as a consequence of):								
l a	d.	-f,per me,g922 12-27	7 11						
Physician/Medical	▼ UNPENDED □ AMENDED 23a,27,28a-	-1, per me, g922 12-21	7-11 SM						
Ž	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery						
ciar	past 12 months?	=	ancy Month D	ay Year					
ysi	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)							
直	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?					
ا و			1 Yes 2 No 3 Prob	abiy 4 Unknown					
Completed by			24a. Was an 24b. Were au	topsy findings available					
臣			performed? death?	ompletion of cause of					
	OF Missesser of Country		1 ✓ Yes 2 No 1 ✓ Ye	s 2 No					
a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Out	26.Place of Death (Check tpatient 3 DOA Other Nursin							
은	1 Yes 2 No	tpatient 3 DOA Other Nursir	ng Home 5 Residence 6 Other						
흥	1 Natural 5 Pending fd 10-18-11 fd		28d. Describe how injury occurred unknown						
Cat:	2 Accident investigation								
Certific	determined to the	m, street, factory, office building, etc.	28f. Location (Street and Number or Rui or Town, State) 157 M1111	ngton Rd.					
	Pound at	Residence	Millington, MD.						
edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inv	In occurred at the time, date and place, and vestigation, in my opinion, death occurred a	I due to the cause(s) and manner as state at the time, date and place, and due to the	ed. e cause(s)					
Ş Me	and manner stated.  29b. Signature, and title of certifier.	29c. License number							
	9/49/14-67/1/1968	O.C.M.E.	29d. Date signed (Mon						
	11,000 1 61,000 61001	U.U.M.L.	0000001 13, 2011						

34567

Registrar

900 W Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

egistrar's Signature

Victor Weedn MD JD

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 216 Henry Nobil Yates Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Western MD Regional Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 X M 2 □ F 68 214-42-0761 Maryland **Director** 01-07-1943 Usual Residence of Deceden 10d. Inside City Limits and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director 1 Yes 2 No Frostburg MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21532 19219 National Hwy NW 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. White 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Technician Electrician Be 18. Mother's Name (First, Middle, Maiden Surname permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) Maletta M. Lancaster Yates ပ Henry R. Yates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 19219 National Hwy NW Frostburg, MD 21532 Connie Yates 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Cumber land Crematory 10-24-2011 1 Burial 2 Cremation 3 Removal from State Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Sowers Funeral Home, Frostburg, MD 21532 M00547 M Saver 60 W. Main St., H161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset of Death Immediate Cause (Final Physician/ carebrodascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). as the burial-transit and Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform after death.

Director: After this certificate h 1 🗌 Yes funeral director, 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1. Natural 5 Pending Accident Suicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1. Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed call

28 2011

se of Jeath (Item 23a) (Type, Print) MD

32. Regist ar's Signature

D0059987

10-23-2011

11-08037	
Cyprien Aza	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ypnen Aza	1- For State Ce	rtificate of Death	Reg. No. 2011 3456
Physician/	1. Decedent's Name (First, Middle,Last)  Cyprien T. Aza		2. Date of Death  Month Day Year 1533 hrs
edical Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October 26, 2011 1533 hrs 4c. County of Death
	Baltimore Washington Medical Center	Glen Burnie	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 215-65-8138 1X M 2 F 41	last birthday)  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	- Enroing Vacala
ýu e	Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Location	10d. Inside City Limits
<b>*</b>	MD Prince George's	Sever	
E Fig. 19	10e. Street and Number 8367 Flintlock Court	10f. Zip Code 21144	10g. Citizen of What Country? USA
or items 23	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in UArmed Forces? 1 Yes 2 No	J.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
s after de ral", or ainer m	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Yes 2 No specify:	Specify: Black
2 hours after "natural"  Examine	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti	red)
5-0036 ed within 72 hour lygiene "natu other than "natu he Medical Exar Completed	4	Ice Cream Maker	Private
21215-0036 ould be filed within 72 hou Mental Hygiene. I marked other than "nat ic event, the Medical Exa To Be Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surname)
- 13 E E G	Bernard Aza 19a. Informant's Name/Relationship (Type, Print )		Rural Route Number, City or Town, State, Zip Code)
MD d 2 sho lith and n 27 is numati	Corlence Aza/ Wife	8367 Flintlock Court Place of Disposition (Name of cemetery,	, Severn, Maryland 21144  Date   20c. Location - City or Town, State
Baltimore, MD 2121 permit, Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other fraumatic event, TO Be	4 V R wint 0 Commettee 2 Demoved from State	crematory or other place) Family Plot 12	/03/2011 Njindom, Cameroon
Balti permit. Departm Importa	21. Signature of Funeral Service Licensee	7474 Landover Road	3. Jenkins Funeral Home 1, Landover, Maryland 20785
Physician Medical	23a. Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line.		r respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Cardiova		
	Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence	of).	
mine mine	if any, leading to immediate cause. Ervar Underlying Cause (Disease or injury that initiated		
60, ate be executed hysician and e burial - transit Medical Examiner	events resulting in death) Last  Due to (or as a consequence d.	of):	
e execucian and inial - tr	UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760, To the Rospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are cleath.  To the Funeral Nicetor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit perfical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of prescription of the past 12 months?  1 Unknown  23c. If yes, outcome of prescription of the past 12 months?  1 Unknown	2 Fetal death 3 Ectopic pregna	23d. Date of delivery  Month Day Year
P.O. B s that the d gned by the e detached by the by the by the by the by the by the by Phy	•	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. ralo Attending Physician: The law requires that the series of the se			24a. Was an autopsy performed?  1 ✓ Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check  P ER/Outpatient 3 DOA Other William Nursi	only one)  ng Home 5 Residence 6 Other:
ding Physical After this funeral dir	1 Ves 2 No 1 Inpatient 2 No	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
ending sath. or: Af	1 V Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No	
Division of spital or Atending hours er cleath.  Meral Pirector: After filled in by the funer Centification:	3 Suicide 6 Could not be determined (Specify)	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attend within 24 hours er cleath To the Funeral Litector: completely filled in by the	4 Homicide determined (Specify)  29a. Certifier (Check only)  Certifying Physician: To the best of my knowled	ath occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
To the Ho within 24 i To the Fu completely	one) 2 Medical Examiner: On the basis of examina and manner stated.	and/or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	October 27, 2011
	30. Name and address of person who completed use of death (lite	V/7	
	Russell Alexander MD. Aseistant Medical Exa	aminer 900 W. Baltimore Street, Baltin	more, MD 21223
Stat	31. Date filed (Month, Day Year) 32. Registrar's Signa	ature 1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Medical rtoper Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington **Funeral** If Under 1 Year 8. Date of Birth

June 24 Age (In vrs. last birthday) 9. Birthplace (State or Foreign <sup>Year)</sup>1928 1 ▼ M 2 □ F Director 215-24-0518 83 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel 1 Yes 2 X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7466 Furnace Branch Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 X Never Married 2 Married þ Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 0 self employed moving & hauling Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other the contract of the contract o 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Garrison Aiken Sr Frances Isabel Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Aiken/nephew 562 Forestview Road Linthicum, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Funeral Service L Ronal d State and Address of Faciliboard 655 W. Baltimore Street Baltimore, MD 21201 T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ LOSMIDUM COLINS DIFILIL Medical Due to (or as a consequence of) Examiner 5cp53 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of ACIDOS55 MUMBOLIC attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical HYPERKALLMA IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_ in the past 12 months? signed by the atte Pregnant at time of death Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed's 1 Yes 2 No 1 Yes 2 Wo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate the funeral director. Director: / upleted filled in by 24 hours a Funeral I

Aiken

BACI MONE WASHINGOON MEDICAL 31. Date filed (Month, Day, Year) 31

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

Investigation 6 Could not be

determined

Accident

Suicide

4 🗌 Homicide

(Check

only one

29b. Signature and title of certifie

State

Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work?

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

Covin.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) OCTUBER 25,2011

City or Town, State,

GLEN BURNIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34571 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26 Month Physician/ BRISCOE 9:08 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LOCHEARN BALTIMORE CARE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Director 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No ANDALISTOWN 10e. Street and Number 10g. Citizen of What Country? APT Funeral 530 ESOURCE U.S.A 108 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) YOME MAKER Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JONES ELIA MAE 19a. Informant's Name/Relationship (Type, Print)
BETTY A. BR. SCOE
CRAND DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 67126 BALTIMORE, MARVIAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place (10) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 31/2011 BALTIMORE, MARYLAND 22. Name and Address of Father DERRICK C. JONES, FIH, P.A. 4611 PARK HGTS. AVE., BALTO, M.D. 21215 21. Sig vure of Funeral Service Li 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition HYPERTENSIVE Physician, CARDIU NOUSP ATH Medical resulting in death) Examiner Sequentially list results if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ng physician and as the bunal-transit the Hospital or Attending Physician; The law requires that the death certificate be executed STAGE that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician doe detached for use as the buriet by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No 1 Yes 2 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 Tes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 € 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tuno 10-26-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UZO UNEGISU, MD. 2835 SMITH AVENUE # 203 BACTIMURE, MD 21209

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 3 1 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Ple	ease Type or Pri					•		_		
		For State	State of M	aryland / l		rtment of F ificate of D	Health and Death	Mental Hy		001	1 21.5	1.0
Physic	rian/	1. Decedent's Name (First, Midd	tle, Last)	BRI			Journ	2. Date of Po	Reg. No eath Da	7	3. Time of Death	
Med	dical	4a. Facility Name (if not institution	on give street and number	Dar			r Location of Deati	10	7	2 Year	12417	М
Exam	iner	Mandrin Hospi				Harwoo		1		anne Aru		
Funera		5. Social Security Number	6. Sex	e (În yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth	O Bir	tholago (State or Fore	ign
Directo		212-52-4175 Usual Residence of Decedent	T I WI Z CF	60	Yrs.			Nov 13	3, 19	950	Maryland	1
land show dat	to	10a. State 10b. Coun	ty	10c. City, Town	n or Loca	ation					10d. Inside City Lim	
Mary 28a-1 notifie	Director		Arunde1	Pas	sade						1 🗆 Yes 2 😾	No
with the	ral	10e. Street and Number 8384 Oak Holl	low Drive			10f. Zip Code	21122		10g. Cr	itizen of What Co	ountry?	
eath v tems er mu	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W		ispanic Origin? (S an, Mexican, Puert	pecify Yes or No	-	14. Race - Ame		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Mala Examiner must be notified at	d by	1 Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce	If Voc Give	No	_	Yes, specify Cuba		o Alcan, etc.)		Black, White Specify: W	te, etc. hite	
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filed wall Hyg	Be	17. Father's Name (First, Middle	, Last)		- Cr Cr	HIII I D C L C	18. Mother's Na	me (First, Middle			<u> </u>	
Ild be Ment narked	욘	John Edgar Bi						an Joyc				
d 2 shou alth and 27 is n		19a. Informant's Name/Relation Linda A. Retz		198			and Number or Ru 11ow Dri				ip Code) 1122	
ye 1 and t of Hea If item or othe		20a. Method of Disposition	n 3 🗆 Removal from State			ition (Name of atory or other plac	ce)	Date	20c. L	ocation - City o	r Town, State	
iit. Pag artmen ortant: injury	47	4 🕅 Donation 5 🗆 Other			22	Name and Address	on of English					
Depart Impo	ouc	21. Signature of Fune a Service Rona Ld	Wade Ty	ector	Št	ate Anat	ss of Facility Comy Boar	d 655 W	. Ba	ltimore	Street	
		23a. Part L. Enter the disease, shock, or heart failure. List Immediate Cause (Final	or complications that cause t only one cause on each lin	d the death. Do r	not enter	the mode of dyin	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between	
Physiciar Medica		Immediate Cause (Final disease or condition resulting in death)	a MUC	LLPL		Scl	ERO:	SIS			Onset and Death	5
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	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):							_
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s that t gned b	by P	Part II. Other significant condi	tions contributing to death	out not resulting	in the un	iderlying cause gi	ven in Part I.				to the cause of death?	_
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has b	Completed							24a. Wa aut per	s an opsy formed?』		utopsy findings availal completion of cause	
an: The tificate tor, pag	Be Co	25. Was case referred to medical	al			26. P	lace of Death (Che	1 Yes	2 2 N	lo 1 □ Y€	es 2 No	_
hysici: nis cer 1 direct	Io B	examiner? 1  Yes 2 No	Hospital:	ient 2 ER/O	utpatient	3 DOA Oth	er: 4  Nursing I	Home 5 Res	sidence	6 Other (Spe	city) MANDE	I
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Attenor deat sector:	Certificate:	3 Suicide 6 Cou	28e. Place of In	ury - At home, fa	arm, stre		iles 2 🗆 140				ural Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial			building, e	c. (Specify)					wn, State			
29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause and due									e cause(s) and manner s	tate		
To th	-	29b. Signature and title of certif		00.	)		e number			ate signed (Mon	th, Day, Year)	
		- G T - C	Jan >	-PU	(Turn C	(at)	8105	>	(.6	1231	-0()	_
		on Name and address of person	wind completed cause of	Company (Item 23a)	ES P	Depen	se Ho	by A	100	polis	M-D.514	0
Si	tate	31. Date filed (Month, Day, Year,		rar's Signature	bak	V		J		(		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 40 PM 2011 Regina June Bannon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Savage timore Rosedal FRANKLIN Hospital Center 8. Date of Birth 9. Birthplace (State or Foreign ocial Security Numbe **Funeral** 1 □ M 2 🛛 F Months Min. 09/03/1932 219-28-5927 79 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1 Brett Court, Apt. #212 21221 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Bannan, Regina Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify If Yes, Give Year or Dates Specify. White Completed 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ Margaret Allender Edward P. Gutridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Bannon (Son) 2017 Paulette Road, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Most Holy Redeemer 11/03/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ days dis se or condition rulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events Infection Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 Yes 2 WNo completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျှ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature title of ce 29c. License number 29d. Date signed (Month, Day, Year) D006209 29-201 on who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore, MD 21237 9000

Registrar

State

VR

905

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 27, 2017 Laura May Bridges 12:35 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9804 Philadelphia Road Baltimore Rosedale 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours 219-70-2144 01/05/1958 **Director** 53 Virginia Usual Residence of Decedent 3a or 28a-f show t be notified at within 72 hours after death with the Maryland 10b. County Director 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Rosedale 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must 9804 Philadelphia Road 21237 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces? "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates and 2 should be filed within 72 hour. Health and Mental Hygiene. tem 27 is marked other than "natulother traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald Dawson Flora Ann Estes 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Reese Bridges, Jr. 9804 Philadelphia Road, Baltimore, Maryland 21237 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit, Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Ind 10/28/2011 | Baltimore, Maryland 21. Signature of Furnant Service Licens e <sup>22. Name and Address of Facility</sup> Bruzdziński Funeral Home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final MSION Onset and Death Ph, sician Medical resulting in death) ulmonay Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): arenal attending physician and for use as the burial-tran that initiated events resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year 1 ☐ Yes 2 L 9 ☐ Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did topacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes မြ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home this Residence 6 Other (Specify) Certificate: Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury in 24 hours and the Funeral Director: Afterwated filled in by the funeral filled in by the funer 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title son who completed cause of death (Item 23a) (Type, Print) Boltimare Bebir Road. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #28b Per ME G920 10/31/2011 JH
State of Maryland / Department of Health and Mental Hygiene

1- State amend items 28e, f per me g921 11-2-11 yt
Registrar

Reg. No. 2 | | . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 0109 to be Zesli Medical 4a. Facility Name (if not institution, give street and number) Examiner n, or Location of Death 4b. City 4c. County of Death Itmove Social Security Number If Under 24 Hrs. 8. Date of Birth If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday Months Min 01/28/1967 **Director** 220-64-4273 44 1 XM 2 □ F MD 28a-f show 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Arbutus 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5234 Dewitt Road 21227 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Worker Warehouse 8vrs Be 7. Father's Name (First, Middle, Last)
William Peter Barry, Jr. 18. Mother's Name (First, Middle, Maiden Surname) ပ Charolette Pawlie WALLiam P. Berry Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5234 Dewitt Road Arbutus MD 21227 Father 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Atlantic Crem 10/21/11 Glen Burnie MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility  ${\sf Simplicity}$   ${\sf Crem}$  &  ${\sf Fun}$   ${\sf Serv}$ ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician MONAR disease or condition Medical resulting in death) Due to (or as a consequence of) EXAMINER **Examiner** ION APPROVED BY ME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached f Yes 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital မ 2 No Other: 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of UNK Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending down 2010 1 Yes 2 X No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Friend's Home 28f. Location (Street and Number or Rural Route Number, City or Town, Stateunknown determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 58 2011 30. Name and address of person who completed cause of death (Item 23a) UNG MI 600 State Registrar

amend #17&19a Per FH G930 8/23/2012 JH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10d Per FH G921 11/04/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2011 **Physician** FRANCES MICHAELS CHANDLEE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/AROLAND PARK PLACE HEALTHCARE CENTER Baltimore 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Maryland 90 Mar 22, 1921 219-07-5590 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show ages 1 and 2 should be filed within 72 hours after death with the Maryla the Health and Mental Hyglene. If field F27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at XX Yes 2 7 4 10 Directo Baltimore City Maryland N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21211 830 West 40th Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Swats Maybelle Robert Ernest Michaels မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 515 Charles Street Avenue, Towson, Maryland 21204 Robin Chandlee (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Green Mount Crematory 10/31/2011 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) 21. Sign tur of Funera Service de nisse <sup>2</sup> Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. acute stroke left cerebral temisphere Immediate Cause (Final hysician disease or condition resulting in death) Medical Due to (or as a consequence of): Years Examiner perfeneur Cerebro vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 10 2 1100 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Beath Check onl one Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d, Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ▶ M Babelle Mac Gregor MO 7 13657 Oct 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGREGOR, 700 W 40th STREET, BALTISTORE, DD. 21211 MI IS ABELLE 31. Date filed (Month, Day, Year) OCT 3 1 2011 32. Registrar's Signature State Park Registrar

/ DHMH 17 Rev 1/2001

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magazie .	Examir	er	4a. Facility Name (if  Doctor 's						4b. City, 1		Location nham	of Death			c. County of Prince		orge'	S
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Maryland 2	id be filed w Mental Hygi <b>arked othe</b> l <b>atic event, 1</b>	To Be	17. Father's Name (F										(First, Middle N. Ly		n Surname)			
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Baltimore,			20a. Method of Disp 1 📉 Burial 2 [ 4 🗌 Donation	☐ Cremation		val from Stat	cei	ace of Dispo metery, cren Vetera	natory`or ot ens Ce	her place emet	ery	11/3	/2011	Ch	Location - C e1tenh	ıam,	Mary	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fur	hney	N. (	Corn	elius	7	474 L	ando	ver :	Road,	B. Jer Lando	ver	s Fune Mary	ral lan	Home d 207	85
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. Box 68	Hospital or Attending Physician: The law requires that the death certificate be 44 hours affer death.  43 hours affer death  44 hours affer death  45 hoursel Director, Affer this certificate has been signed by the attending physicited filled in by the funeral director, page 2 should be detached for use as the but affer the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 4	Live Birth	e of pregnand 2  Fetal at time of de	death 3 🗆	Ectopic p Other (spe		ý 				23d. Date Mont		very Day	Year
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Division	al or Attendi s after death al Director: A ed in by the f	Certificate:	3 Suicide 4 Homicide	6 Could determ	not be		njury - At hom etc. (Specify)	ne, farm, stre	eet, factory,	, office			28f. Location City or To			or Rura	Noute Nu	mber,
_	To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: At completed filled in by the fu	Medical		☐ Medical B	xaminer: Or	the basis of	examination a	and/or invest	igation, in n	ny opinio	n, death c	occurred at	d due to the c the time, date e, and due to t	and place	ce, and due t	the c	ause(s) and	manner state
	To t With To t		29b. Signature and t	title of certifie						License		751			ate signed (			//
			30. Name and addre	ess of person	who complet	ted cause of	death (Item 2	23a) (Type, P	Print)	- ·	1 - 1	2005	Rive		-/-	M	2,	727
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26,28b,d per me g920 10-31-11 yt State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 28 Year 1 Month 10 DELLEDONNE FALON 1412 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SHOCK TRAUMA N/A BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Jan 19, 1983 221-66-1257 1 🗆 M 2 🖵 F **Director** 28 Delaware Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Delaware New Castle Wilmington 1 X Yes 2 □ No 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? Funeral 813 North Scott Street 19805 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Retail Sales Representative Ò Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked, any injury or other traumatic ew once. Gina Delle Donne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Delle Donne (Mother) 813 N. Scott St., Wilmington, Delaware 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 A Other (Specify) Entombment cemetery, crematory or other place, Cathedral Cemetery Nov. 3, 2011 Wilmington, Delaware Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home. P.A. 237 Fast Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TRAUMATIC ARREST HOURS disease or condition Medical resulting in death) WEDICAL EXAMINER Due to (or as a consequence of) **Examiner** HEMORRHAGE CERTIFICATION APPROVED & Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Loder Examine Due to (or as a consequence of): DEGLOVING attending physician and for use as the burial-transit THIGH INJURY Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? signed by the atter Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2. ☑ No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d Describe how injury occurred subject struct subject driver of an SUV collided with a pickup truck 1 Natural 2 Accident 8:05 5 Pending 28/11 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State)
Rt 213@Still Pond Road Kenn 4 - Homicide determined Roadway Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1720903203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10v MO OLTSB R 22 3 State Registrar

amend 23a,pt.I,28b,28d-e,per me,g922 12-2-11 sm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Teresa P. Davis 11:40 M 2011 Oct. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice Mt. Airv Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) Director 216-88-2194 1 M 2XXF 48 Yrs Jan 30, 1963 MD Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director Frederick 1 Yes 2 😾 No Ijamsville Maryland Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11301 Windsor Rd. 21754 United States "natural", or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 14. Race - American Indian Armed Forces? Black White etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. White Specify: 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Carroll Hosp. Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald A Hall Joan Ann Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Amber N. Davis 9704 Thompson Dr. Ijamsville, MD 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Crematory 11/2/2011 4 Donation 5 Other (Specify) Winfield, MD Signature of Euperal Service Licensee 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, 21784 2 W. Old Liberty Road Winfield. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) conds Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Pregnant at time of death Month 1 Yes 2 4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 prior to completion death? autonsy Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) TOSO CE 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at House 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending iniury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2011 30. Name and address of person who corrected cause of death (Item 23a) (Type, Print) 21702 B 46 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34580 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 <u>Sarah Elizabeth Emerson</u> MC. Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** MOSPITAL ALTIMO HANE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗹 F Days Hours Min 10/11/21 90 Yrs Maryland Director 215-16-1340 Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 909 S. Beechfield Avenue 21229 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hairdresser Hair Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry J. Kaufman Mary Agnes Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21229 3906 Colechester Road Gemma Coleman Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗀 Removal from State cemetery, crematory or other place, injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/31/11 Baltimore, Maryland Baltimore Crematory Signature of Funeral Service Dicensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, followed as cardiac or respiratory arrest, followed as cardiac or respiratory arrest, followed as cardiac or respiratory arrest, and the cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Enysician/ erebrovascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of,: if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: signed by the attendin 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P. Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? disease. 24a. Was an has autopsy Yes a No of Vital completed filled in by the furreral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division ☐ Accident ☐ Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 26388

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

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900

S. CATON AVE, BALTIMORE

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edward Allan Ev		1- For State	Sta	te of Maryla		artment o		d Menta	l Hygiene	D 11	20		1 3458				
Physicia		Registrar  1. Decedent's Name	e (First, Middle,	Last)					2. Date of				3. Time of Death				
Medical Exami		Edward A	Allan Ev	ans Sr					Month Octobe		011		0734 hrs				
		4a. Facility Name (i		-	ımber)		4b. City, Town, or Hagerstown		Death								
		31 E. Wash 5. Social Security N		. Sex	7. Age (In yrs.	Inet hidhday)		Aldre IR Date o	Washington  8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of								
Funeral Director		216-70-2			7. Age (III yis.		If Under 1 Year Months Day		Min.			Foreign	n				
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ku a	١	10a. State	10b. County		10c. City	, Town or Local	tion						10d. Inside City Limits				
nd sbow	۲	MD	Washir	ngton		Hagerst	own				1 Yes 2 X						
Aaryla 28a-f	Director	10e. Street and Nu		_			10f. Zip Code			10g. Citizen of What Country?							
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "astural", or items 23a or 28a-f show mastic event, the Medical Examiner must be notified at once.		31 E. Wa	ashingto	n Street				21740			USA						
th with	Funeral	11. Marital Status  1 Never Marrie	ed 2 Man		cedent Ever in U orces?		as Decedent of Hi 'es, specify Cuba			No-	14. Race - White,		can Indian, Black,				
er dea	Ē	3 Widowed		1 Yes	2 No	1 1	Yes 2X No	specify:			Specific	•					
irs aft	ð	15. Decedent's Ed		L or Dates:			nt's Usual Occupa	, ,	d of work done	16b.	Specify: Kind of Busi		ite				
72 hou	Completed	Elementary/Seco		College (			nost of working life						sali idustry				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica			12	0		t	truck drivertranspor										
5-0 iled w Hygie		17. Father's Name		•				18.Mother's N	lame (First, Midd	le, Maider	iden Surname)						
121 d be f fental	B	Nelson Eugene Evans Helen  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro										Ctata	Zin Codo)				
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	٩	Helen E				1.0											
e, M and 2 Fealth frem 2		20a. Method of Dis	position			Place of Dispos	sition (Name of ce		Date Date	20c.	Location - 0	City or	Town, State				
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Marin Marin		or condition resulting	ng in death)	Due to (or as a	consequence o	of):											
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uted id ansit		events resulting in	death) Last	d.	Consequence	01).											
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical	UNPENDED AMENDED															
certificate be anding physici	cian/Me	IF FEMALE: 23b. Was decedent		23c. If yes,	outcome of preg		etal death 3	Ectopic pr	regnancy	23	3d. Date of d Month	-	ay Year				
x 68 h certi tendin use a	<u>S</u>	past 12 months		4 Pregr	ant at time of de	looth -	ther (Specify)		ognanoy	1	Morra		a, 15a.				
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Division pital or Attendii ours after death. eral Director: A	12	2 Accident 3 Suicide	Investig	28e Plac	e of Injury - At h	nome, farm, stre	et, factory, office	building, etc.		n (Street	and Number	or Rui	ral Route Number, City				
Dital ours a ours a filled	Certific	4 Homicide	determ	ined (Specify)					OI TOW	n, otato)							
Division  To the Hospital or Attent within 24 hours after death  To the Funeral Director:	edical	29a. Certifier (Check only		<b>sician</b> : To the besiner:On the basis		_											
To the To the Comp	Medi	29b. Signature and		and manner s			29c. Licen:						oth, Day, Year)				
			Ca. B	o IMA			O.C.				tober 19,						
	1	30 Name and addr	ess of person w	ho comeleted cau	se of death (Item	m 23a)					1						
	Ì	Laron Locke		sistant Medica			altimore Stree	et, Baltimo	re, MD 2122	3							
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 – For** State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 5244 AM Cassandra Garrison 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A Baltimore Union Memorial 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** Days Months 08/101th3D1/1957 Maryrand 1 □ M 2 F 220-68-8667 Director 54 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must he marified \*\* 10a. State Director 1 🄀 Yes 2 □ No Baltimore N/ACIM 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 1504 Upshire Rd. Apt 1E 21218 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes ∠ If Yes, Give 1 ☐ Yes 2 No Specify. Specify Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) N/AUnemployed 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Doris Morton Walter Garrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1504 Upshire Rd. Apt 1E, Balto., MD 21218 Careyna Green (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 10/28/11 |Baltimore,MD on-site Crematory | 4 ☐ Donation 5 ☐ Other (Specify) 2140 N. Fulton Ave., Baltimore, N PA 21217 21. Signature of Funeral Service Licensee MD 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death stastatic Bladder reass Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of: the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After of the funeral ompleted filled in by the funeral completed filled f Natural Accident 5 Pending injury work? 1 Yes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert AT2438946 October 23, 2011

State Registrar

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30. Name and address of person who

31

PEJMAN K 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

E.

UNIVERSITY PRKWY

Baltimore, MD18

completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

KHARAZI

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34583 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Marto be 35 M Medical 4c. County of Death a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HIMOVE 8. Date of Birth 7. Age (In yrs. last birthday) 9, Birthplace (State or Foreign If Under 1 Year 6. Sex **Funeral** Months Hours Min 10 10 734 77 196-38-8839 **Director** 1 □ M 2**X** F PA Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Funeral Director Schuylkill Porter Township 1 Yes 2 No PA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 174 W. Grand Avenue 17980 U.S.A. th and Mental Hygiene. 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. Completed by 1 Never Married 2X Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Margaret Shive Levi Schaeffer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Ave., Porter Twp., PA 17980 174 W. Richard L. Harner (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ gremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Peters Cem. 10/25/11 Orwin, PA Βt. 22. Name and Address of Facility Dimon Funeral Homes, 21. Signatu 201 E. Market St., Williamstown, PA 17098 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi): Physician/Medical Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown should be detached the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 1 🗌 Yes 2 🗌 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 Yes မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Dáte of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death I hours after death.
uneral Director: After thely filled in by the funera 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a

To the Funeral Completely filled Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DUO Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

**State** 

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State	State of Maryla	-	nent of Health a cate of Death	nd Mental H	201	34584
	Registrar  1. Decedent's Name (First, Middle, La	ast)	Oertine	cate of Death	2. Date of D	Reg. No. — U	3. Time of Death
Physician/ Medical	MARSHA		HUD	SON.	Month CCTOBE	Day Year 2011	177145014
Examiner	4a. Facility Name (if not institution, giv			City, Town, or Location of		4c. County of Deat	th
Funeral		10 PUINS HUS F Sex 7. Age (In yrs.	last birthday) If I	BALTIMORE Jnder 1 Year   If Under 24		irth 9. Bir	thplace (State or Foreign
Director		1 □ M 2 🔀 F	Yrs. Mo	nths Days Hours	Min. (Month, E	ay, Year) Co	untry)
nd now	Usual Residence of Decedent  10a, State 10b, County	100.0	ity, Town or Location		7	1-193 / 1/-(4	10d: Inside City Limits
lanylar Ba-f sl iffied a	hel Bal	4	01/2				1 ☐ Yes 2 ☐ No
the N a or 28 se not	10e. Street and Number	1	10	f. Zip Code		10g. Citizen of What Co	puntry?
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at  To Be Completed by Funeral Director	7244 Early	bolden L	ane	21208		U.S.	9.
ter deal , or iter aminer a by Fu	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No		Decedent of Hispanic Origin specify Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ame Black, White	
Irs afte	3 ☐ Widowed 4 🅦 Divorced	If Yes, Give Year or Dates.	1 🗆 🕆	es 2 No Specify:		Specify: 3	ack
"natu edical	15. Decedent's (Specify only highest of		(Give kind o	Usual Occupation of work done during most of	of working	16b. Kind of Business	/Industry
should be filed within 72 hours at and Mental Hygiene. is marked other than "natural" aumatic event, the Medical Exa To Be Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NO	T use retired)	٤	Itzal	th
illed w Il Hygi Vent,	17. Father's Name (First, Middle, Last,	)	1 // //		's Name (First, Middle	e, Maiden Surname)	
ld be fi Mental arked atic ev	John Nelsi	on Timpso		14:1		aney	
shou h and 7 is m raum	19a. Informant's Name/Relationship (	(Type, Print)	19b. Mailing Ad	dress (Street and Number		per, City or Town, State, Zi	o Code) 21208
and 2 Health tem 2 other t	20a. Method of Disposition	1=3 daughter	Place of Disposition		lden Lar	20c. Location - City or	
Page 1 ment of tant: If i	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, cremator	or other place)	1-1-2011	Balta 1	ad.
permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau	21. Signature of Funeral Service Lice	nsee Daylo	22 Nar	ne and Address of Facility	oglass Fr	o. hd. 212	ce f.A.
	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only						Approximate Interval Between
Physician/	Immediate Cause (Final disease or condition	SEPSIS					Onset and Death
Medical Examiner	resulting in death)	Due to (or as a conse	quence of):				
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	guence off:				
xecuted n and al-transit Examiner	cause. Enter Underlying Cause (Disease or injury	240 10 (0) 45 4 501100	que1100 01/.				
an and rial-tra	that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):				
cate be executed physician and s the burial-transit edical Exami	•	<b>d</b>					
ding p	IF FEMALE:	23c. If yes, outcome of pregr	nancv				
eath o	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o	rtal death 3 🗌 Ect	opic pregnancy er (specify)		23d. Date of de Month	Day Year
at the death certifing by the attending etached for use a Physician/M	9 Unknown	9 Unknown					
es that igned be de	Part II. Other significant conditions	contributing to death but not n	esulting in the under	ying cause given in Part I.		tobacco use contribute to	
peen s should						Yes 2 No 3 F	
The law require cate has been signated a should I							topsy findings available completion of cause of
cian: Th ertificate ector, pa Be Cc	25. Was case referred to medical			26. Place of Death	1  Yes	s 2 √No 1 ☐ Ye	s 2 No
hysicii his cer al direc	examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3	Other:		sidence 6 Other (Spec	cify)
ing Pr offer th unera	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?		how injury occurred	
or Attending P after death. Director: After t I in by the funera Certificate:	2 Accident Investigation 3 Suicide 6 Could not	he	N	1			
al or A	4 Homicide determined	d 28e. Place of Injury - At I building, etc. (Spec.	ify)	астогу, опісе		(Street and Number or Ru own, State)	iral Houte Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Medical Certificate: To Be Completed by Physician/Medical Exam	(Check 2 Medical Exar	ysician: To the best of my kno miner: On the basis of examinati arse Practitioner: To the best of	on and/or investigation	on, in my opinion, death occ	urred at the time, date	and place, and due to the	cause(s) and manner stated
To the within To the comp	29b. Signature and title of certifier	il se Practitioner. To the best of	my knowledge, deal	29c. License number	and place, and due to	29d. Date signed (Mont	
	> 3 show			RES 000		DCTOBER	26 2011
	30. Name and address of person who				0.0 1		
Chair	BISHOW CHANDI 31. Date filed (Month, Day, Year)		600 N	WOLFE ST	BALTIMU	(E, MI) 21	284
State Registrar	OCT 3 1 2	32. Restrar's Sign	A TO	10.00			
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For State Registrar	State o	f Marylan		artment <i>tificate</i>			ınd M		giene Reg. No.	2011	345	85
Physici		1. Decedent's Name (First, Middle, Las Milton H. Harten								2. Date of Dea Month Octobe:	Dey	Yeer 2011	3. Time of Death	14
/Medic Examin		4a. Fecility Name (If not institution, give	street and nur	mber)		,.		Location of	f Death		4c. C	County of Deatl	1	
Funeral Director		2011 Hillcrest Ro 5. Social Security Number 6. S 217–18–6155		7. Age (In yrs. 88	ast birthday) Yrs.	If Under 1		1 Oak If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 4/1//	h	Co	e nplece (State or Fore Intry) yland	∍ign
Maryland f show	ō	Usual Residence of Decedent	more.	10c. City	y, Town or Lo	cation ynn Oa	ık						10d. Inside City Lim 1 ☐ Yes 2 ₩	
ith the ? or 28a-	Director	MD   Baltin	1101.6		- Gw	10f. Zip C	Code				10g. Citiz	en of What Co	untry?	
death w ms 23e	Funeral	2011 Hillcrest Ro	12. Was Dece	edent Ever in U.	S. 13.		207	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 1	USA 4. Race - Ame		
Z.15-UU36 thin 72 hours after death with the Marylar e. en "nature!", or items 23a or 28e-f show Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Married 4 Divorced	Armed For 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 No		r Yes, specm 1 ☐ Yes 2		Specify:	, Pueno i	Rican, etc.)	1	Black, White	White	
1.215-50035 within 72 hours after death with the Maryland ene. then "nature!, or items 23a or 28a-f show the Madical Examirat must be incillised at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1	I-4or 5+)	(Give life. I	dent's Usual kind of work DO NOT use	done d retired	luring most )		ng		d of Business/		
N BES	Be Co	12 17. Father's Name (First, Middle, Last)			Vend	ing Su	ıper	18. Mothe	r's Name	(First, Middle,	Maiden S		1g	
Maryland d 2 should be file th and Mental Hy ?? is marked oth treumatic svent	ToE	Howard B. Harte			10h Mailis	a Address /	Ctroot	-		M. Sedi		Town, State, 2	in Code)	
C = 44 F		John H. Harten /	Son			Hillcr					•	larylan		
Oroth oroth		20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 1)		State	Place of Dispo emetery, crer	natory or oth	ner plac			ate		cation - City or	Town, State . Mary land	d
Baltim permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Lice		Lak 5		. Name and	Addres	s of Facility	y Lou	ıdon Pai	rk Fu	neral laryland		Т
الم		23a. Part1. Enter the disease, or conditions shock, or heart failure. List only	plications that cone cause on e	caused the death								ir y rand	Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	(or as a conseq		ardi	ion	relli	soft.	7				
Examiner	_	Sequentially list conditions.	b. Due to	or as a conseq	Dic	beter	N	lell.	teus					
cuted nd ransit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	(0) 23 2 001304										
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, P.O. BOX 68/60, that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live t	tcome of pregna birth 2   Feta hant at time of d	Ideath 3□	Ectopic pre					2	3d. Date of dei Month	ivery Day Year	
(A) & E) &	by	Part II. Other significant conditions of Atrial Fibrilla		eath but not res	1.1-	nderlying car	use give	en in Part I.			obacco us		the cause of death	
The The ate h	Completed	Upper GI ble	col +	ty per	tenses	Tu, He	9p2	dipu	den	autor	osy rmed2/	24b. Were au prior to death?	itopsy findings avail completion of cause 2 \( \text{No} \)	able of
OT VITAL F Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Othe			ne 5 Hesi		Other (Spe	c(fv)	
	lon: T	27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date (Mon		28b. Time of Injury	28	c. Injun Worl	/ at	4	28d. Describe l				
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Mospital or A 124 hours after the Funeral Direction by Electrical Control of the Funeral Direction by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the b	e best of my kno asis of examina ner stated.	wledge, deat tion and/or in	h occurred a vestigation, i	it the tin	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
To the vithin 2 To the comple	Me	29b. Signature and title of certifier		Attens	leng	29c.	License	a number			29d. Date	a signed (Mont	h, Day, Year)	
en i		30. Name and address of person who	completed caus	se of death (fler	sical	Print)	ט	506	051		10	731/2	011	
VV		Dr. Alan Reising 31. Date filed (Month, Day, Year)	01-70	Geip	e Rd	Sui	te	215	- Co	tonsv	lle	, Md.	21228	
Sta Registr		OCT 3 1 2	011 2	www /	8. 40	ale								

DHMH 17 Rev 1/2001

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			For	State of	Maryland					and M	lental Hyg	giene				
			1 - State Registrar	Loot		Cer	tificate	of D	eath		2. Date of Death 3 Time of Death 3 Time of Death				586	
F	hysicia	n/	1. Decedent's Name (First, Middle									Day Year				
o majo	Medio Examin		Joseph W. Ho  4a. Facility Name (if not institution)		er)		4b. City,	Town, or	Location o	f Death	Octobe	Der 14, 2011   8:14 AM M				
_ غمريد	LAGIIIII		104 Tilghmar	Avenue #1	10		Centreville					Queen Ar				
	uneral irector		5. Social Security Number 215-36-2439	6. Sex 7. 1 ★ M 2 □ F	Age (In yrs. la	Months Days Hours Min. (M					8. Date of Birth (Month, Day Feb 9,	(Year)	Cou	place (State ontry) h Caro		
land	show d at	tor	Usual Residence of Decedent  10a. State  10b. County	_	10c. City	, Town or Loc	ation							10d. Inside C	City Limits	
Mary	28a-f iotifie	Director		Annes	Cei	ntrevi									s 2 X No	
ith the	23a or st be r		10e. Street and Number  104 Tilghman A				10f. Zip		21617			10g. Citizen o		intry?		
ath w	ems s	Funeral	11. Marital Status	12. Was Decede		. 13. V	Vas Decede			in? (Spe	cify Yes or No- Rican, etc.)			can Indian,		
27275-UU36 within 72 hours after death with the Maryland	do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2X Marri 3 Widowed 4 Divorced	If Ves Give			Yes, speci			Puerto	Rican, etc.)	Specia	ack, White, y: <b>W</b>	<sub>etc.</sub> hite		
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and be filed	narked othe	To Be	17. Father's Name (First, Middle, L Fred Hope	ast)					18. Mothe		e (First, Middle, I gie Vio					
Maryi 2 should	isn		19a. Informant's Name/Relations				_				i Route Number					
ore, e 1 and of Hea	<u>'</u> = '>		Pearl A. Hope/			104 ] ace of Disposemetery, crem	sition (Nam	e of			10 Cent	revilla 20c. Location				
Saltimore,	Important; any injury c		4 X Donation 5 ☐ Other (S 21. Si nature Superal Service	1///	<b>ze</b> ctor	S <sup>22</sup>	. Name and	d Addres	s of Facility	hard	655 W.	Baltin	ore S	Street		
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	sician/		shock or heart failure. List of Immediate Cause (Final disease or condition											Interval Be Onset and	tween	
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pe	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. Due to (or	as a conseque	ence of):	o M	લીતે	405					570	os.	
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UIVISION OT VITAI RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director, After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 □ Fetal ntattime of de	death 3	Ectopic p Other (spe		У			1	ate of deli	-	Year	
that the	ned by t e detach	by Phy	Part II. Other significant condition	ons contributing to dea	th but not resu	ulting in the u	nderlying c	ause giv	en in Part I		23e. Did to	bacco use cor	tribute to	the cause of	death?	
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<b>Ital</b> ician:	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ce of Deat							
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UIVISION tal or Attendir rs after death.	a <b>l Direct</b> led in by		4 Homicide determ	ined 28e. Place of	Injury - At hor etc. (Specify)		et, factory,	office			28f. Location (S City or Town		ber or Run	al Route Num	ber,	
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To #	To th	_	29b. Signature and title of certifier  Mussul	ea.s	ele.	J 200		License		7		29d. Date sign		Day, Year)		
			30. Name and address of person		of death (Item	23a) (Type, P	rint)	hen	A 1	7,09	ton und	216	01	<u> </u>		
	Stat Registra	te	31. Date file (Month 3av, Year)		istrar's Spnatu	ure farke	1		D		.5.0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl Physician/ HOLMES MILDRE Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Seasons Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Social Security Number 224 **Funeral** Months Hours Min **Director** N. Carolina 10/01/1923 88 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c City Town or Location Director 1 Yes X No York PA N/A10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 17404 105 Mill Run Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. ò 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 □₩Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Joseph Banks Seamstress should be filed with and Mental Hygien is marked other th 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosa Gilbert William Payton injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 105 Mill Run Rd., York, PA 17404 Joanne A. Rollins (daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State . Page 1 1 XBurial 2 Cremation 3 Removal from State 10/29/11 Timonium, MD Valley Ponation 5 Other (Specify) Dulaney Synaty e of Funeral Service Licensee Funeral Home, Baltimore, Shaddess of Briown Jr. N. Fulton Ave., AGM 21217 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failt Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Esqueritially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events trar and resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death the t detacl signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the older of the funeral bletely filled in by the funeral presents. 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. Medical 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

within 2

To the F

complet

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title

DHMH 17 Rev 06-2011

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER D2/2 20 1°1' 9:27 P IBO AIME Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S ST. THOMAS MORE NURSING HOME HYATTSVILLE 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours APRIL 10 IVORY COAST Director 177-76-9322 1960 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No VA GREAT FALLS **FAIRFAX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IVORY COAST 9700 GEORGETOWN PIKE 22066 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 XMarried ò 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: "natural", Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CAR DEALERSHIP OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KEA. GUEHAI GANI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 GEORGETOWN PIKE GREAT FALLS, VIRGINIA 22066 DELPHINE IBO/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/2011 ABIDJAN, IVORY COAST WILLIAMSVILLE CEME. ; 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 23a. Part 1. Enter the shock, or heart f Approximate Interval Between Immediate Couse (Final Onset and Death Physician/ Tuberculous ENCEPHALITIS WIM Hydrocephalus disease or condition Medical resulting in death) ✓ Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Encephalopathy, Anoxic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Respiratory Failure Vantilator Dependent 24a. Was an Jas page 2 autonsv Sackal Decubitus vicer certificate | Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number D01852 October 23 2011

State Registrar 4203 QUEENSBURY Rd HYAHSUILE MID 20781

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of Ma	-	Certificate				lene leg. No. $\mathcal{I}$	1 31.589		
	Physicia	an/	David  1. Decedent's Name (First, Middle, Last DAVID	K.		JACKSON			2. Date of Deat		ar 3. Time of Death 4:30 A M		
	Medic Examir		4a. Facility Name (if not institution, give	street and number)		4b. City, To		cation of Death	OCTOBEL	4c. County of D	Death		
فحرب	Funeral		358 SHADY GLEN  5. Social Security Number 6. Securi		(In yrs. last birth	hday) If Under 1	Year If	HEIGHTS Under 24 Hrs.	8. Date of Birth	9.	GEORGE S  Birthplace (State or Foreign		
	Director		241-78-8045 1.  Usual Residence of Decedent	X M 2 □ F 7. Age 6.	3	Yrs. Months	Days H	ours Min.	MARCH Day	3 1948 B	ROOKLYN, NY		
	yland -f show ed at	ctor	10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits		
	he Mar or 28a	Dire	MD PRINCE G  10e. Street and Number	EORGE'S	CAPITO	L HEIGHTS			1	1 Yes 2 ☐ No			
	s 23a onust be	Funeral Director	358 SHADY GLEN	DRIVE		2074				USA			
980	e filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4又 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates.	er in U.S. o	13. Was Deceder If Yes, specify	Cuban, M	lexican, Puerto F	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. BLACK		
15-0	72 hou n "natu Aedical	nplet	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted</i> )		Decedent's Usual ( (Give kind of work ) life. DO NOT use re	done dunn	n g most of workir	ng	16b. Kind of Busine	ess Industry		
212	within giene. ner tha t, the N		Elementary/Seconday (0-12)	College (1-4 or 5+	,	S DRIVER	eurea)			GOVERNM	ENT		
and	be filed ental H ked otl ic even	To Be	17. Father's Name (First, Middle, Last) James RAYMOND JACKSON				(First, Middle, M	Maiden Surname) <b>?</b>					
Maryland 21215-0036	1 and 2 should be fi of Health and Mental fitem 27 is marked rother traumatic ev		19a. Informant's Name/Relationship (T)		City or Town, State								
	f Health item 27 other tra		AYANA B. JACKSO	N/DGI	20b. Place of	Disposition (Name	of			20c. Location - City	MARYLAND 20743		
Baltimore,	Page 1 ment of tant: If it jury or o		1 ☐ Burial 2 🙀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)		y, crematory or othe DD F. HOM	E CRE	EM. 11-4	-2011	RALEIGH, N	NORTH CAROLINA		
Bai	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	ee	$\supset$						RAL HOME, INC. YLAND 20785		
			23a. Part 1/ Enter the disease, or companied to the shock of heart failure. List only of	plications that caused t ne cause on each line.	he death. Do n			uch as cardiac or	r respiratory arre	est,	Approximate Interval Between		
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	gnant	neopla	Sm	of 11	iver		Onset and Death Uハくへいい		
	Examiner	_	Sequentially list conditions,	b.	onsequence o								
	ted nsit	ımine	cause. Enter Underlying Cause (Disease or linjury	Directo (or sella)	füribeqiterific ü	ý.							
	icate be executed physician and s the burial-transi	edical Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence o	f):							
760	icate be physic s the bi			d									
Š R	e death certificate be executed the attending physician and thed for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	☐ Fetal death	3 Ectopic pre 5 Other (spec				23d. Date of Month	f delivery Day Year		
	requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but	not resulting in	n the underlying cau	use given ir	n Part I.			e to the cause of death?		
	The law rec cate has bee page 2 sho	Completed							24a. Was ar autops perform 1 \(\sum \) Yes	ned? prior deat	e autopsy findings available to completion of cause of h? Yes 2 🖾 No		
Vital	ysician; s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	t 2 T FR/Out	tpatient 3 DOA	Other:	of Death (Check		ence 6 Other (S	Dacifu)		
ion of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Certificate: 7	27. Manner of Death  1 K Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	28b. T		. Injury at work?	1		w injury occurred	респу		
JIVIS	al or Att s after d I Direct d in by	3   Suicide 6   Could not be determined   Suicide 4   Homicide   A   Homicide   Suicide determined   Suicide   Suici											
	the Hospita in 24 hours the Funera	Medical	(Check 2 \( \sum \) Medical Exami	sician: To the best of m ner: On the basis of exa e Practioner: To the be	mination and/or	r investigation, in my	opinion, de	eath occurred at	the time, date an	d place, and due to t	the cause(s) and manner stated.		
	To 1		29b. Signature and title of certifier from the control of the certifier of	ippman.	MO		icense nun $25001$	mber	2	9d. Date signed (Mo			
			30. Name and address of person who c	<del>// · · · · · · · · · · · · · · · · · · </del>					L	30200			
	Stat	e	31. Date filed (Month, Day, Year)	32. Segletrar's		DRIVE #G	LINT	HICUM, M	ARYLAND	21090			
	Registra		OCT 3 1 20	11 Duna	1.	barker							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State 34590 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 Tear October 8:40 AM M Bruce Johnson Jr Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore 1111 Park Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours Min 219-38-5976 **Director** 1 💢 M 2 🗆 F 69 Dec 20, 1941 Usual Residence of Decede Maryland show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 0a. State 10b. County Director MD 1 X Yes 2 No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21201 1111 Park Avenue #303 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 han "natural", c Medical Exam 1 ☐ Yes 2 🔀 No Specify: Specify: black 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 0 security guard hotels Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk marked ပ္ Bruce Johnson is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Shardai Thomas/granddaughter 1506 Adamsview Road Baltimore, MD 21228 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Å Other (Specify) in State 22. Name and Address of Facility Maryland Sign Fre of Fu Fral Service Licen State Anatomy Board Baltimore, MD 21201 Street 655 W. Baltimore 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RENAL CELL CARCINOMA METASTATIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical **Hospital or Attending Physician:** The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☑ 9 ☐ Unknown by the Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> DIABETES MELLUTUS 1 Tes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERHENSLO-24a. Was an autopsy performed? Yes 2 2 🗌 No 1 Yes 124 hours after deam.
124 hours after deam.
126 Funeral Director: After this certification in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 🗆 Other (Specify) Hospital: 1 ☑ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No injury 1 🔁 Natural 5 Pending Accident
Suicide Investigation 6 Could not be To the Hospital or Atter within 24 hours after ded To the Funeral Director completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 024781 10/13/4 Name and address of person who completed cause of death (Item 23a) (Type, Print) W. 1001

State

Registrar

31. Date filed (Month, Day,

2011

32. Registrar'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 34591 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 2011 4:45 AM Marjorie Adell Kessler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 92 Country) 10/12/1919 Director 219-01-9875 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at anoe. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 K No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 18776 Diller Dr. 21742 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Nidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker her home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest Hall Annabelle Hatfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Pearl St. Bishopville SC 29010 Kirk Kessler (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2XXCremation 3 🗀 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 10/31/2011 Winfield, MD 22. Name and Address of Facility Burrier-Queen Funerla Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 akl A Kellen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Anset and Death Physician Cardiofulmonary about disease or condition Medical resulting in death) Examiner Metachatic UNKnown Sequentially list conditions, Examine if a, y, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d, Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed page 2 should 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Athroscler performe Yes 2 No Be 25. Was case referred to medica filled in by the funeral director 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural After t 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending s after death. 2 Accident
3 Suicide Investigation М 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completed fil 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 2011 29c. License number 9 44996

DHMH 17 Rev 7/2009

A

State Registrar 32. Registrar's Signatu

rson who completed cause of death (Item 23a) (Type, Print)
Malik Mn 2031) Copposes Rd Boonsboro MD 2-17/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34592 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mollie KARBEL October | 27, 2011 1:45 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Collingswood Nursing Center Rockville 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 7. Age (In vrs. last birthday) 1 □ M 2 🕱 F 86 Months Days Hours 11. 1925 080-18-3780 Usual Residence of Decedent 10a State 10h County 10c. City Town or Location 10d. Inside City Limits Maryland Bethesda 1 ☐ Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7555 Springlake Drive #C-2 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 School System Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Wilson Becky Semelman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Northfield Gate, Pittsford, NY Lori Karbel, Daughter-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/38/11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance Memorial Park Clarksburg, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Servic Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage end iomyopalh disease or condition resulting in death) ue to (or as a consequing e of): Due to (or as consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examiner

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Physician/Medical

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Certification: To

Medical

physician

requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Hospital or Attending Physiclan:

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medical Experiment must be notified at

death v

filed within 72 hours after

12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "

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permit. Pages 1 and Department of Health Important: if item 27, any Injury or other tra

3altimore, Maryland 21215-0036

/Medical

Director

Funeral

<u>À</u>

Completed

Be ည

> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident

3 ☐ Suicide 4 Homicide

29a. Certifier

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 ☐ Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

20850

29d. Date signed (Month, Day, Year)

 $VO_{K^{0}}$ State

31. Date filed (Month

Julia Kariya, 299 Hurley Avenue, Rockville, MD parke

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G920 10/21/2011 Jh State of Maryland / Department of Health and Mental Hygiene 20

34593 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 12, 201<sup>Year</sup> 10:15 AMM Margaret Kassouny /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Vantage House Columbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Months 1 ☐ M 2 7 F Yrs Director 159-34-2943 86 Feb 26, 1925 Lebanon Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at Director MD 1 □Yes 2√ No Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 5400 Vantage Point Road #803 21044 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 📉 No Specify. Specify: white ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. than College (1-4or 5+) 5+ Elementary/Secondary (0-12) 12 12 should be filed with and Mental Hygier 7 Is marked other th professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yevinige Y. Terzian Yeghia Sarkis Kassouny ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. Arpia Ayvazian/niece 70 Columbia Road Arlington, MA 02474 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice License 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the use as f IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) 9 Unknown 2 s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autons performed? Yes 2 \(\sum{No}\) 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after deat To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 47447 Oct 12, 2011 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 6334 Cedar Lane Columbia, MD 21044 Andrew Lazris 31. Date filed (Month, Day, Year) 0CT 3 1 2011 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34594 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C Physician/ 9:04 AM tallie Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** atomore If Under 24 Hrs 8. Date of Birth (Menth, Day, Yea 9. Birthplace (State or Foreign last birthday If Under Age (In vrs. **Funeral** Days Hours Min 1 M 2 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No 7/HIMORE 10g. Citizen of What Country? 10f, Zip Code 0e. Street and Number Funeral 2122 115A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Marital Status "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 Yes 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced AMERICAN Completed TICAN er than "natur, the Medical E 16b. Kind of Business Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mecone. Elementary/Seconday (0-12) College (1-4 or 5+) OUD Be Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, 2 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code, street nomas Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State , crematory or other place) Woodlawi, Cometex 4 Dovation 5 Other (Specify) re of Funeral Service Licensee of Facility w. m. Morey 23a. Part 1. Enter the grease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit mor Due to (or as a consequence of) ding physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 5 Other (specify) Pregnant at time of death led by the a detached for 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 this certificate Yes Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Manner of Daat Date of injury Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 28c. Injury at (Month, Day, Year) injury 5  $\square$  Pending 2 No 1 Yes Investigation Accident Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 10

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 34595 For State Registrar Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear 5:00 PM **Physician** aclovas October 23 201 Laukaitis /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University of Maryland Medical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 GM 2□ F 1931 Vrs Lithuania 79 219-30-4859 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic svent, the Medical Examinational be notified at 1 ☐ Yes 2 ☐ No Director N/A Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 1120 Hollen Road Completed by Funeral illed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes of No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Pyes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Factory 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) should be fi. Be if Health and Menta Andrius Laukaitis 0na Skirkaite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is many injury or other traum 1120 Hollen Rd., Baltimore, MD 21239 Aldona Buda (Per. Rep.) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Removal from State 3 □ Removal from State Loudon Park Cemetery 10/28/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the mode of dying, such as cardiac or respiratory arrest, shock, which are failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician Septicemia /Medical Due to (or as a consequence of): Examiner Acute Kidney Sequentially list conditions, if any, leading to immediate that in a cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit My elody splastic Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by t 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes page 2 autopsy performed? Yes 22 No 2 XNO 1 Yes 1 Yes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case relerred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA ို 2 ER/Outpatient 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 1 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) in by t 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 23. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sammore South Greene JNECT 22 Juson oh 31. Date liled (Month, Day, Year) PA \*A 32. Pagistrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 25 per me c920 10-31-11 vt
State of Maryland? Department of Health and Mental Hygiene 2

amend item 24a per verb g921 11-1-11 vt
Certificate of Death

Reg. No. 34596 1 - For State Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day MACJOCH MICHAEL 6:20 P M Oct 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Courtland Gardens Nursing Home <u>Pikesville</u> 8. Date of Birth (Month, Day, ) **July 21** Social Security Number Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign **Funeral** Hours 1 🔀 🗴 2 □ F Days 54 **Director** 219-58-0709 Maryland Usual Residence of Decedent 28a-f show aţ 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 ☐ Yes XXXNo MD Baltimore Reisterstown 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 23 Glyndon Dr. T-121136 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes XX No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0 þ XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Toll Taker Transportation 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gray William J. Macioch Guyla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Macioch/Father 311 Norgulf Rd. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) All Faiths Crematory & Chapel 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 11/1/11 4 Donation 5 Other (Specify) Manchester, MD Funeral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Ph, sician/ PROSTATE CANCER disease or condition resulting in death) Medical Examiner PATHOLOGIC FRACTURE LUMBAR SPINE Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on and I-transit RIGHT HEMIPARESIS that initiated events MEDICAL EXAMI Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical SEIZURE DISORDER attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by POST TRAUMATIC Division of Vital Records, or Attending Physician; The law requires STRESS Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perform death? Yes 2 K No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No injury s after death.

I Director: Aff
d in by the fur Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide within 24 hours aft

To the Funeral Di

completed filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title MD D27157 uctober 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYNOLD DEPESTRE 3100 LORD BALTIMORE DR. #110 BALTIMORE MD 21244 31. Date filed (Month, Day,

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 2. Date of Death 3. Time of Deat Decedent's Name (First, Middle, Last) <sup>1</sup>10714/2011 6:00pM Andrew McClendon Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Examiner Severna Park 111 Sabrina Lane 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Country) (Month, Day, Yo 01/18/ **Funeral** Months Days Hours 219-76-1505 1 XM 2 □ F 1963 48 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> with the Maryland 1 🗆 Yes 2 🔀 No Director Severna Park Anne Arundel MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21146 Funeral 111 Sabrina Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2X No 1 Never Married 2 X Married Black þ 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Butcher Elementary/Seconday (0-12) Meat Cutter 8yrs Page 1 and 2 should be filed with ment of Health and Mental Hygier ant: If item 27 is marked other it 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mattie Samuel McClendon ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) wife Sabrina Lane Severna Park MD 21146 Diana Taylor-McClendon 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other pl Atlantic Crem Glen Burnie MD 10/20/11 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facilitisimplicity Crem & Fun Serv Funeral Service Lig rhomasAllenPA 7090 Ridge Rd Hanover MD Mom 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one on the on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year Month Dav in the past 12 months? Pregnant at time of death 2 No ned by the 1 L Yes 2 L 23e. Did tobacco use contribute to the cause of death? Director: After this certificate has been signed by d in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 2 🗆 No 1 Tyes 26. Place of Death (Check only one 25. Was case referred to medical Be Other: examiner? Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 မ 1 Yes escribe how injury occurred 28d. D 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Deat Certificate: injury Natural Accident 5 Pending 1 🗌 Yes 2 🗍 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospital within 24 hours a To the Funeral C Medical completed (Chec

Registrar DHMH 17 Rev 7/2009

State

only o

29b. Signatu

32

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ October 24, 2011 6:05 AM M Loretta A. Metzler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey Hospice Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 🗆 M 2 🛛 F Months Days Hours Sept 22, 1924 87 Director 218-14-0186 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 801 Winters Lane 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Stephen J. Eluskie Helen Loretta Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Mattingly/daughter 3430 81st Street Jackson Heights, NY 11372 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service Li 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line.

Immediate Cause (Final disease respiratory) Interval Between Onset and Death Physician/ METASPATIC BUNDDEL disease or condition MANTH Medical resulting in death) **Examiner** MONTH Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year 1 Yes 2 1 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 1 Yes Yes 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 No Accident Suicide Investigation

Maryland 21215-0036

Baltimore,

9

ナ

Certificate: Medical

29a. Certifier (Check only one)

24 hours a

State Registrar ess of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

re and title of certifie

3 1 2011

6114 CAMPFIRE COLUMBIAMD 21045

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0026327

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	e of Ma	aryland / De	•				Mental Hy	/gien	е				
			State Registrar				Certifica	te of	Death	า		Reg. N	.201	3	14599	9	
	Physici	ian	1. Decedent's Name (First, Mid	dle, Last)							2. Date of De Month	D.	ay Year		Time of Death		
-	/Medi		Audrey Mayer		1		41 07		1				2 26 201		: 30 AM		
	Examir	ner	4a. Facility Name (If not institut  Overlea Healt)		,	tor		y, Town, oi Balti		or Death		40	4c. County of Death				
	Funeral		5. Social Security Number	6. Sex		e (In yrs. last birth		er 1 Year		er 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Bir	thplace	(State or Forejg		
	Director		212-34-1169	1 □ M 2 🔯	F	74 Yr	Months.	Days	Hours	Min.	Jan 21	ay, Year • 19	37	ountry) `	unk		
_	ים לי		Usual Residence of Decedent														
- 1	h the Marylan or 28a-f show	<u>-</u>	10a. State 10b. Coun	ty		10c. City, Town o									side City Limits		
Of	8a-f	ecto	MD			Balt	imore								Yes 2 □ No	,	
E	a or 2	à	10e. Street and Number 225 York Road				10f. 2	ip Code	2121	2		10g. C	Citizen of What Co	ountry?			
7	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jieal Examinal must be notified at	Completed by Funeral Director		1- 12 W/oc I	Docadant	Ever in U.S.	12 Was Das				pecify Yes or No		14. Race - Am		dian	_	
T:	fter d r iten imer	ᇤ	1 ☐ Never Married 2 ☐ Ma	Arme	d Forces?		If Yes, sp	ecify Cuba	an, Mexic	an, Puerto	Rican, etc.)	_	Black, Whit		ulati,		
17	urs a	þ	3 Widowed 4 Divorce	If Yes	, Give or Dates:		1 □Yes	2₹No	Specif	y:			Specify: wh	iite			
// 5-0	72 ho natur	etec	15. Decedo	ent's Education nest grade complet	ted)	16a. D	ecedent's Us Give kind of w	ual Occup	ation	net of work	unk	16b.	Kind of Business	/Industry	unk		
121	ithin ne.	Jd u	Elementary/Secondary (0-12)		ge (1-4or 5		fe. DO NOT	use retired	i)	JSE OF WORK	arig						
12	filed withir It Hygiene.  other than rent, the	ਲ	unk	unk			-	. 1			(F' . 1 & 4 ' . 1 )				,		
and	i be fi intal } ed ot ed ot	Be	17. Father's Name (First, Middl	e, Last)				unk	18. Moti	ner's Nam	e (First, Middle	, maide	n Surname)		unk	ζ	
W E	thould Me mark mark	ပ္	19a. Informant's Name/Relation	oshin (Type Print)		10h N	Inilina Addra	on (Straat	and Num	har or Pu	ral Pauta Numb	ar City	or Town, State,	Zin Code			
Ø ₽	nd 2 s lith ar 27 is rtrau		Overlea Nursin				-				timore,		21206	zip Code	<del>)</del>		
G,	f Hea	-	20a. Method of Disposition	0		20b. Place of D	isposition (Na	ame of	-		Date		Location - City or	Town, S	State	_	
AUDPEY $M$ Eltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s any injury or other traumatic event, Item Marical Examination once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🐼 Other		om State		crematory or	other plac	:e) :								
alti	permit. Departm Importa any inju		21. Signature of Euneral Service Ronald			·	22. Name a	and Addres	ss of Faci	ity or a	1 655 tJ	Do	ltimore	Ctr	oot		
Ω.	S E E E		Konalo	3/Nag	De	ector	Balti		-			• ра	ITCIMOLE	SCI	eet		
			23a. Pa. 1. Enter the divease, show, or heart failure. Li	or complications that only one cause	nat caused on each lir	the death. Do not	enter the mo	de of dyin	ig, such a	as cardiac	or respiratory a	arrest,		Appr	roximate val Between		
	Physician		Immediate (Final disease or condition	. ME	ETA	STATIO	C B	RE	A57	-	ANC	Ef	) ,	Onse	et and Death		
	/Medical Examiner		resulting in death)	Due	e to (or as	a consequence of)											
	_xammer	_	Sequentially list conditions,	b	1. (												
	nsit	in in	Sequentially list conditions, it any course to the cause. Enter Underlying Cause (Disease or injury that initiated events	₹	10 (01.08	a consequence of)											
,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as	a consequence of):											
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		Medi	IE EEU E												=-		
Вох	eath certific attending p for use as	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome	of pregnancy 2 ☐ Fetal death	3 ☐ Ectonic	pregnancy	u.				23d. Date of de				
0.	at the des by the al tached fo	Physician/Me	in the past 12 months?	4 □ P		time of death	5 Other (s						Month	Day	Year		
₽.	hat th ed by detack		9 ☐ Unknown Part II. Other significant condi	tions contributing t	to death hi	it not reculting in th	o undorlying	causa siw	on in Port	1	23a Did i	tobacco	use contribute t	o the car	is a of death?		
of Vital Records,	signed of be det	0	and in out of organical in out of the	and contributing t	o dedir be	it not resulting in a	e anderlying	cause give	on mir and	1.			2 □ No 3 □ F			n	
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<u>a</u>	ilcian; Th certificate ector, pag		25. Was case referred to medic	al T							1 ☐ Yes	2 12 17		s 2 🖭	No		
5	ysician; is certific director,	o Be	examiner?	Hospital:	□ Innatia	nt 2 ER/Outpa	tiont 2 🗆 🗆	Othe			h (Check only o		6 ☐ Other (Spe	15 - 1			
o	g Physical control of the serial of the seri		27. Manner of Death	28a. D	ate of Injur	y 28b. Tim	e of	28c. Injun Work		nuising ne	28d. Describe			спу)		_	
io	ath.	atio	L Mooidoin	tigation	Month, Day	( <i>Year</i> ) Inju	M		Yes 2[	□No							
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined 28e. Pl	ace of Inju	ry - At home, farm . (Specify)	street, facto	ry, office			28f. Location ( City or To		and Number or Fi	ural Rou	te Number,		
	Hospital or Attending Physician; The law requires that the death certif 24 hours after death. Funeral Director; After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	. Se									·		,				
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director, Aft completely filled in by the fun	ledical	29a. Certifier 1 Certify (Check only 2 Medical	I Examiner: On th	the best on the basis of the basis of	of my knowledge, of examination and/otted.	eath occurre or investigation	d at the tin n, in my o	ne, date a pinion, de	and place eath occur	, and due to the rred at the time,	cause( , date a	(s) and manner a nd place, and du	s stated. e to the c	cause(s)		
	To th vithir To th comp	2	29b. Signature and title of certifi	er \Lambda	1			c. License					ate signed (Mon				
			> CUfor	How	al.	no		00	06.	178	9	001	UBER	6.	2011		
	_		30. Name and address of person 5730 CANPB.	who completed c	ause of de	eath (Item 23a) (Ty	pe, Print)	ORP	AIN	EC	OFOR 1.	Au	VAHIN	40			
			3430 CANPB 31. Date filed (Month, Day, Year	ELL BLV	D, -	r's Signature	BA	167	In	ORF	M	21	1236			_	
	Stat Registra	re	OCT 3 1	2011 /2	e de la	r's Signature	all										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BRYANT LEE PRUNTY October 28, 2011 1415 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Baltimore 7821 Price Lane Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Hours 217-80-9034 Maryland Director 1 🔀 M 2 🗆 F 51 Feb 12, 1960 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2X No Baltimore Maryland Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 **USA** 7821 Price Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) 12 College (1-4 or 5+) Trucking Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Katherine Lue Prunty Lee Prunty Doy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Southorn Road, Middle River, MD 21220 Gregory Prunty (Brother) 2011 20c. Location - City or Town, State Bryant 20a. Method of Disposition 20b. Place of Disposition (Name of November 10 Creen Mount Crematory 11/3/2011 Baltimore, Maryland 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Dabroski/Chojnacki Funeral Homes, P.A. 21. Sign Me a Turney College Martin D. Lawson ELD FUNERAL HOME, INC. Baltimore, Maryland <del>21212</del>21224 ) York R Dundalk 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ardiac or respiratory arrest, Immediate Cause (Final Arterioscherot Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 X Yes 2 \( \subseteq \text{No} \) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No eral Director: A Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check d title of certifier 29d. Date signed (Month, Day, Year, 18667 October 29 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRIMBLE HILLCT LUTHER VILLE. MD 21093 MD 6 91217 MILITELLO 31. Date filed (Month, Day, Year) State Registrar

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0/28/

amend #5 Per FH G924 2/08/2012 JH. State of Maryland Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rosalyn PLOTKIN October 27 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House Montgomery Hospice 8. Date of Birth Jan, 9ay, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 1 🗆 M 2 💢 F Y1928 Director Usual Residence of Decedent در is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified مهم 10a. State 10b. County 10c. City, Town or Location Director Rockville Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20852 6111 Montrose Road #1011 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. White Armed Forces þ ☐ Yes 2 🗓 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes : If Yes, Give 1 ☐ Yes 2 🕅 No Specify. Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Erving School Union Business Manager Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ္ Molly Wallace Saul Bean 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 18028 Bilney Drive, Olney, MD 20832 Lanny Plotkin, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Leicester, MA Holy Society Cemetery 10/30/11 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line 23a Part Immediate Cause (Final disease or condition Lung Cancer Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown ō Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending Division s after death.

I Director: Af in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4:45 P

9. Birthplace (State or Foreign

Massachusetts

20012

Month

29d. Date signed (Month. Day, Year)

20855

Dav

1 ☐ Yes 2 ☐ No

Year

Hospice

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 Yes 2 X No

DeDur ...
31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Miller, 6001 Muncaster Mill Road, Rockville, MD

pleted f

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 🖟 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2143201

Division of Vital Records, P.O. Box 68760

		For State Registrar			d / Depa	artment of I tificate of I	Health		Mental Hyg	giene Reg. No. 2	011	. 34602	
Physician Medica Examine	al r	1. Decedent's Name (First, Middle Beverly L. Rajc. 4a. Facility Name (if not institution 5156 Perry Rd.	a	nber)		4b. City, Town, o		of Death	2. Date of Dea Month Oct 2	Day 4c. Cour	Year 2011 hty of Death	3. Time of Death 3:30 P M	
Funeral Director		5. Social Security Number 216–24–6257  Usual Residence of Decedent 10a, State 10b, County	6. Sex	7. Age (In yrs. la	ast birthday)  Yrs.  y, Town or Log	Mt. Airy If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp Count TN	try)	
	al Directo		roll		Airy	10f. Zip Code				_	of What Cour	1 ☐ Yes 2XXXNo	
hours after death	습		If Yes, Gi- Year or D	16a. Deced	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 ☑ No lent's Usual Occup	Specify pation	n, Puerto	Rican, etc.)	Spec	9. Birthplace (State or Foreign Country) TN  10d. Inside City Limits 1			
e filed within 72 Intal Hygiene. ed other than "r event, the Med	o۱	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, L	ŕ		(Give i	kind of work done O NOT use retired)	during mos	ner's Name	e (First, Middle, I	MD Dry Maiden Surna	dock		
and 2 should b Health and Mer tem 27 is mark		William F. Jones  19a. Informant's Name/Relationsh  Debbie Rajca (Da  20a. Method of Disposition	nip (Type, Print)	20b. P	5156	g Address (Street Perry Rd	and Numb	er or Rura . Air		City or Town			
permit. Page 1 Department of Important: If any injury or once.		1XX Burial 2 Cremation 4 Donation 5 Other (S	3  Removal from	State Hoo	denpy1	Cemeter  Name and Addre  Trier—Qu  112 W. 01	y [1	1/2/	2011	Whitwe	11. TN	1	
Physician/ Medical		2 Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	aa	ich line.	SENT	r the mode of dyin	ig, such as	cardiac c	r respiratory arre	est,		Approximate Interval Between Onset and Death	
be executed sician and sician and purial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	(or as a consequ (or as a consequ	,							-	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the by Madical Cartificate. To Re Completed by Division Medical	iysiciali/iweulcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	nant at time of d	Ideath 3 🗌	Ectopic pregnand Other (specify)	су					-	
The law requires that the cate has been signed by page 2 should be detailed by Dr.	2	Part II. Other significant condition	ons contributing to c	eath but not resi	ulting in the u	nderlying cause gi	ven in Part	I.	1 ☐ Y	es 2 W No	3 Prob	pably 4 Unknown	
Physician: The law this certificate has tral director, page 2 s	20 00	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2		t 3 DOA Oth	4 ⊔ N	ursing Ho	only one) me 5 Reside	med? 2 No	death? 1 Yes ther (Specify)	2 🗆 No	
al or Attending P s after death. Il Director: After t ed in by the funers	Oci (III) care	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could determ	gation not be ined 28e. Place	th, Day, Year)		28c. Injury work 1 — eet, factory, office	y at :? Yes 2 🗆	No No	28d. Describe ho 28f. Location (St City or Town	reet and Nun		Route Number,	
To the Hospita within 24 hours To the Funeral completely fille		(Check 2 ☐ Medical E only one) 3 ☐ Certifying  29b. Signature and title of certifier	Nurse Practitioner	is of examination: To the best of m	and/or invest ny knowledge,	gation, in my opinio death occurred at t 29c. License	on, death o the time, da number	ccurred at te and pla	the time, date ar	d place, and one cause(s) and one cause(s) and one cause(s)	due to the cau d manner as s ned (Month, L	use(s) and manner stated.  tated.  Day, Year)	
10		30. Name and address of person v  THOM AS  31. Date filed (Month, Day, Year)	who completed caus	VIN TO	23a) (Type, P	rint)	166		Acric		11/201 STM1A	Setre Mynd	
State Registrar		OCT 3 1 2011	Zenen )	egistrar's Signat	Kel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a per dr., g920, 10/31/2011 dhb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARIE F. RUBERRY Medical 0ct ו וחכ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **HARFORD** BEL AIR BRIGHTVIEW ASSISTED LIVING 8. Date of Birth (Month, Day, Year) Sept. 12,1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Social Security Number 7. Age (In yrs. last birthday) Days Hours **Director** 219-14-2432 1 🗆 M 2 💢 F 87 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** must be notified Bel Air Maryland Harford 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a 708 Cedarday Dr. 21015 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes XX No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White XX Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. the llth grade N/A Crown Cork & Seal Assembly Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lester Davis Marie Jaworski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE Page 1 and 2 Beverly Pivec (Niece) 708 Cedarday Drive Bel Air, Md. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. of 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 10-17-2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 21. Signature of Funeral Service Acensee 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) respush Medical Due to (or as a consequence of) Examiner where to Th Sequentially list conditions. Examine if any, leading to immediate cause. Litter ordenying Cause (Disease or injury ue to (or as a consequence of). Dementia use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical  $\#\mathcal{A}\mathcal{J}a\rho + \mathcal{I}$  Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, paar 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decing Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1732255 Octobe 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1) Avio 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Octobe. Physician/ liam Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 13a. Himore Hopkins ohns If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Hours 220-64-5203 1 M 2 □ F Sept.18,1950 Director MD 61 10d. Inside City Limits 28a-f shov 10a. State 10h County 10c City Town or Location Examiner must be notified at Director 1 X Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code o 10e. Street and Number 23a Funeral USA 21213 1300 E. Lanvale St. Apt. 406 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. þ Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 🗌 Widowed 4 🗆 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturiary injury or other traumatic event, the Medical Engle." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) none 8th Disable Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth P.Wainwright William Redding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5532 Silverbell Rd.Balto,Md. 21206 Elaine Morgan (sister) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ★ Burial 2 Cremation 3 Removal from State King Memorial Pk. Oct.29,2011 Balto,Md. 4 Donation 5 Other (Specify) <sup>22 Name and Address of Facility</sup> Calvin B. Scruggs Funeral Home 21. Signature Funeral Service Licensee 1412 F. Preston St. Balte, Md. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed oro nan that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: completely filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has 25. Was case referred to medical examiner?

1 X Yes 2 \( \subseteq \) No 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work? 2 No ☐ Accident ☐ Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my crowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

State Registrar 600 N.

Wolfe Street Baltimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**OCT 31** 

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eec

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of D 1. Decedent's Name (First, Middle, Last) 4:09 AM October 2011 Physician/ Carol Seibert Virginia Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Social Security Number Days Hours **Funeral** West Virginia 04/06/1940 494-42-8159 1 🗆 M 2 🖾 🛊 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County with the Maryland Director 1 Yes 2 No notified Essex 28a-f Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ò ms 23a or must be r U.S.A. 21221 Funeral 17 "N" Timbercreek Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itemany injury or other traumation. 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 XNo 1 Never Married 2 X Married þ Specify Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Weehunt Oleta Sidnev Flack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 "N" Timbercreek Court, Essex, Maryland 21221 19a. Informant's Name/Relationship (Type, Print) Clinton R. Seibert (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 10/31/2011 Bayview Crematory, Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23h Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day Month in the past 12 months? jo Pregnant at time of death signed by the aid be detached for 2 1 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy has page 2 performed? 24 hours after death. Funeral Director: After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ၉ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at filled in by the funeral 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1) CHARLES 6701 KUMAR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 3 1 Registrar DHMH 17 Rev 06-2011

and title of certifier

29a. Certifier

29b. Signatur

To the I within 2 To the I

(Check only one

MD

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

71040

SUITE 4105

29d. Date signed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 1055 PM ine 0 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverview Care Center Baltimore Essex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min. **1XX**M 2□ F **Director** 229-32-6542 81 11/01/1929 Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Exerciner must be notified at 1 Tyes 20 No Director Maryland Baltimore White Marsh 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 5702 New Forge Road 21162 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify þ WWII Specify. 3₺ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Mass Transit Admin. Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Herbert Sauls unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elva Louise Nuckols (Niece) 5702 New Forge Road, White Marsh, Maryland 21162 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 Removal from State Holly Hill Mem. Gard: 10/31/2011 Baltimore, Maryland 4 Donation 5 Dother (Specify) permit. 22. Name and Address of Facilities Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 2 Ja. | art1. | Enj. | the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, neart failure. List only one cause on each line.

Immedia L Cause (Final disease or condition resulting in death)

a. | Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manney of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 Accident after death 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Naomia Nellie Sturm 2: 40 PM Detob 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Healthcare Saverna Park Anne Arundel Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F 78 Hours July 28, <sup>Yea</sup>r 933 Mar Vland 215-28-8942 Director Usual Residence of Decedent show 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f MD 1 Yes 2 No Glen Burnie Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1405 Scanlan Drive 21061 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claduis Lester Randle Francis Marion Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Vicky L. McKain (Daughter) 8257 Ahearn Dr., Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of Baltimore at Corematory @ Loudon Park 20c. Location - City or Town, State 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/11 Baltimore, Maryland Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Par the first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ emente Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No 9 Unknown Year Day Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division 24 hours after death. Funeral Director: Al 2 Accident 3 Suicide Investigation completed filled in by the 1 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

8601 VeTeran

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

575

Millerrulle, md 21108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DORIS 3:48 PM Medical OCTOBER 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARBUR BACTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Hours (Month, Day, Year) 5/2/38 Director 217-34-9506 Vrs Mary land Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter and once. 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits 1 Yes 2 X No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Mountain Road 21090 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Carnival Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Robert Polk Sr Nora T. Lupuss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan S. Scott / 211 Mountain Rd. Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Loudon Park Cemetery 11/1/11 Baltimore. Marvland 21. Signature of Funeral Service Lices 22. Name and Address of Facility Loudon Park Funeral Home <u>3620 Wilkens Ave. Baltimore, Maryland 21229</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Examiner ATHEROS CLEROTIC YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Smokin ( SD YEAR Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ LUNG CANCER Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? EMPHYSEMA 24a. Was an autopsy performe 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) THENICAL DUCTOR D70357 MD

Registrar

State

HOSPITAL 3001 SOUTH HANDYER TREET BALTIMORE MARTLAND

21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH MWATHA HARBOR

11-07928 John Sigmon

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Sigmon	1- For State	State of	Maryland		rtment of <i>tificate of</i>			Menta	ıl Hyg	jiene		21	1	1 3	1.00	
Physician/	1. Decedent's Name	(First, Middle,Last)			-				2.	Date of D			7	3. Time of D	eath	٦
Medical Examiner	COIII D.	igmon								Month October		011		1455 hr	rs	
	4a. Facility Name (if 10142 Bird F	not institution, give st River Road	reet and numbe	er)	4		own, or Lo River	ocation of [				tc. County of I Baltimore	Cour			
Funeral	5. Social Security No		7.1	Age (In yrs. Ia	ast birthday)	If Unde	r 1 Year Days	If Under 2 Hours	24Hrs. Min.	8. Date of	Birth (MN	M/DD/YYYY) S	9. Birth oreign	place (State Wes	or S L	1
Director	236-24-15		2F	85	Yrs.		Buys	riodis		Feb	19,	1926	Cou	<sup>intry)</sup> Virg	ginia	
án)	Usual Residence of 10a, State	Decedent 10b. County		10c. City,	Town or Locati	on							$\neg$	10d. Inside (	City Limits	1
te Maryland or 28a-f show any fied at once.	MD	Baltimo:	re		Midd	ile R	iver						- 1	1 Yes	2 X No	
the Maryland s or 28a-f sh tified at once	10e. Street and Num					10f. Zip					10g. C	itizen of What	Coun	try?		-
the North	10142 Bi	ird River	Road				212	20				U	SA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "satural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once, To Be Completed by Funeral Director	11. Marital Status  1 Never Marrie	d 2 X Married	2. Was Decede Armed Force X Yes	s? 2 No				anic Origin Mexican, P			No-	14. Race - A White, e		an Indian, Bl	lack,	
s after rail", o	3 Widowed	4 Divorced If	es, Giva Year 1			Yes 2							whi			
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5-0036 ed within 72 hour by yignen. other than "natu the Medical Exam Completed	3	iddiy (0 12)	0									railro	ad			ı
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than in earking the Medical FO BE COMPIE	17. Father's Name (F	First, Middle, Last)					18	3.Mother's I	Name (F	irst, Middle	, Maide	n Surname)				1
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Baltimore, pemit. Pages 1 ar Department of Hei Important: If ite injury or other tr	1 = -	Cremation 3	Removal from S	State C	rematory or oth	er place)										
altir mit. P porta ury or	4 X Donation 5 21. Sgnature Fun	otner Spacity: eral Service V ense	20/61	rector	22. N	ame and	Address of	of Facility	ard	655	W T	Baltimo	-	Stroo	+	1
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Physician		disease, or complica one cause on each	ine.			e mode o	dying, s	uch as card	diac or re	espiratory a	arrest, si	hock, or heart	- 50	Approximate Between C	Inset and	Į
≟xaminer	Immediate Cause (F or condition resulting		ntact Shotg											Dea	atn	1
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Examiner	UNPENDED	d	MENDED							<u>.</u>			-			1
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Sox 6876( death certificate e attending phy. I for use as the b	23b. Was decedent p past 12 months?		Live birth	at time of dea		al death	3 [	Ectopic p	regnanc	у	Į	Month	Da	ау	Year	ļ
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On cendin sath.  or: A the fur	1 Natural	5 Pending Investigation	FOUND: Day Oct 21, 201		FOUND: 1450 hrs		1 Ye	s 2 🗸 N	o Si	ubject sl	not sel	f				I
Visi or Att fifter de Direct in by Uffice	2 Accident 3 Suicide	6 Could not be			me, farm, stree	t, factory,	office bui	ilding, etc.				and Number			nber, City	1
Division o spital or Attending hours after death. Tilled in by the frust filled in by the frust Certification:	4 Homicide	determined	(Specify) R	_	-							Road, Middle				4
Division of N  Division of N  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t  completely filled in by the funeral ledical Certification: T	29a. Certifier 1 (Check only one)	Certifying Physician: Medical Examiner	To the best of the basis of ex	my knowledg camination ar	je, death occuri nd/or investigati	red at the ion, in my	time, date opinion, d	e and place death occur	e, and du rred at th	ue to the ca ne time, da	iuse(s) a te and p	and manner as place, and due	to the	d. cause(s)		١
To the Hc within 24 To the Fu completel	29b. Signature and to		d manner state	d			License					l. Date signed			)	1
	. /	///					O.C.M	.E.			00	tober 22,	2011			
20115	30. Name and adding	ss of person who com	pleted cause of	death (Item	23a)								-			$\frac{1}{2}$
OCME	Mary G. Mpr	ole MD. Deput	y Chief Med			W. Balt	imore S	Street, B	altimo	ore, MD	21223					1
State Registrar		312011	32. Regist	rar's Signatur	parke											

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Margie Sigmon	P	For Sa C		:14	aryland		rtment o tificate o			d Ment	al Hygi		Reg. No.	2011 3	34610
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		4a. Facility Name ( 10142 Bird		_	et and number				, Town, or dle Rive	Location o	f Death			c. County of Dea Baltimore Co	
Funeral Director	X	5. Social Security   229-32-1		6. Sex		e (In yrs. Ia 84	st birthday) Y	If Un-	ths Day		Min	Date of E		Fore	irthplace (State or ign ountry) VA
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Baltimore, MD 21215-0036  Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu				I			ip Code				10g. Citi	izen of What Co	untry?
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after the death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	nysician/Medi	IF FEMALE: 23b. Was decedent past 12 months  1  Yes 2 ✓	s?	ne 1 4	Live birth Pregnant at death Unknown		2	Fetal death Other (Sp		Ectopic	pregnancy		23	d. Date of delive Month	ny Day Year
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Division of Vital Records, rat or Attending Physician: The law requirers after death.  "I Director: After this certificate has been sied in by the funeral director, page 2 should the founding the funeral director, page 2 should the funeral director.	Completed		-				-		_			perl 1 🗸 Yes	s an opsy formed?	prior to death?	
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Divisi tal or Att rs after de ral Directo	Certification:	<ul><li>2 Accident</li><li>3 Suicide</li><li>4 Homicide</li></ul>	6 Cou	ld not be	8e. Place of In			reet, factor	ry, office	building, etc		or Town.	State)	and Number or F	Rural Route Number, City
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one) 2		hysician: To miner:On	the best of m	y knowledg								nd manner as sta ace, and due to	
F . § F 8	Me	29b. Signature and	title of certiff			_		25	9c. Licens	M.E.				Date signed (M tober 22, 201	
CME		30. Name and add Mary G. Ru	MO MD	Deputy	chief Medi			00 W. B	altimor	e Street,	Baltimor	e, MD 2	21223		
St Regist	ate trar	31. Date filed (Mon	ith Day Year)	2012	32. registra	r's Signatur	1. 4	are							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

11-07972	
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Charles Jared Segner

lease	ype or Print in Black indelible ink. Ensure All Copies Are Legi	D
	State of Maryland / Department of Health and Mental Hygiene	

2011 34
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		1- For State Certificate of Death		Reg. No.	711 0701
Physici Medical Exami		1. Decedent's Name (First, Middle, Last)	2. Date of De Month October	Day Year	3. Time of Death 1535 hrs
		4a. Facility Name (if not institution, give street and number)  Bowie Heath Center  4b. City, Town, or Location of Bowie	of Death	4c. County of E Prince Ged	
Funeral Director		n/a 1 Months Days Hours		4/1952	o. Birthplace (State or oreign MD
faryland 18a-f show any 1af ouce.	or	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   Anne Arundel   Glen Burnie			10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number  904 Amelia Ave NE  10f. Zip Code 21060		10g. Citizen of What USA	Country?
fter death wi	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Dates:  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No Specify:	Puerto Rican, etc.)	White, e	hite
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Syrs  16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT to Contractor		Home I	mprovement
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Charles J. Segner Jr Ba	s Name (First, Middle rbara J.	Segner	
MD 21 d 2 should lith and Me n 27 is ma	2	19a. Informant's Name/Relationship (Type, Print)  Barbara J. Segner mother  19b. Mailing Address (Street and Num 624 Waterfront	Dr Berk	eley Spr	ings WV
Baltimore, MD 2 bernit. Pages I and 2 shou bepartment of Health and N important: If item 27 is n july or other traumatic		4 Donation 5 Other Specify:	Date 10/27/11		urnie MD
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Allen P.	A 7090Ri	dge Rd H	anover MD
Physician /Medical £xaminer		23a. Parf I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Approximate Interval Between Onset and Death
	7	or condition resulting in death)  Due to (or as a consequence of):  b.  If any, leading to immediate  Due to (or as a consequence of):			
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3760, ficate be executed g physician and s the burial - transit	lical E	X UNPENDED X AMENDED 1 as noted, 23a, pt. II, 27, per	me,g922 12	2-6-11 sm	
		FFEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1	pregnancy	23d, Date of del Month	ivery Day Year
P.O.	ā	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par Cocaine Use			e to the cause of death?  Probably 4  Unknown
of Vital Records, P.O. Box 68 bg Physician: The law requires that the death certificate has been signed by the attendinmental director, page 2 should be detached for use a	Completed			ppsy prior ormed? deat	e autopsy findings available to completion of cause of h? Yes 2 No
Vital F ysician: ' his certifi director, I	Be	25. Was case referred to medical examiner?	Check only one)		
of Vita 1g Physicia fter this ce neral direct	ē	1 Ves 2 No Inspired 1 Inpatient 2 V ER/Outpatient 3 DOA	Nursing Home 5		Other:
C # . ^ 2	ation:	27. Manner of Death  1  Natural 5 Pending 2 Accident  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?		how injury occurred	
Division pital or Attendin ours after death. teral Director: A	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify)	28f. Location or Town,		r Rural Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plact one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		e and place, and due	to the cause(s)
	Σ	29b. Signature and title of certifier  29c. License number			(Month, Day, Year)
		le lui 1		October 27, 2	.011
1	I	30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltir	more, MD 21223		, l
St Regist					
				OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Stokes 1:45AM Jerry 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL DLUWBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VA **Funeral** 1 X M 2 D F Months Days Hours 08-10-1944 231-54-8152 Director 67 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo MD Ellicott City Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral ian "natural", or items 23 Medical Examiner must 5509 Hunt Chase Terrace United States 21043 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) the Chemist U.S. Government Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Carl Franklin Stokes, Jr. Marion Imogene Bott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Hunt Chase Terrace, Ellicott City, MD 21043 Wanda K. Stokes - wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🗷 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 10-26-2011 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility Gary L. Kaufman Funeral Nome at Signat MMP, Inc., 7250 Wash.Blvd., Elkridge, MD 21075 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Myocardial Infarction Interval Between Onset and Death Immediate Cause (Final ORA NAR Ph sician/ hour disease or condition Medical resulting in death) Examiner Cardiovascular Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy performed death? after death. Director: After this certificate 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 🗆 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifi 29c, License numbe 29d, Date signed (Month, Day, Year) 041699 October R. Hillims ed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane, Colur State 28 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:10 PM 10 201 Medical 4a. Facility Name (if not instituțion, give street and number, Examiner Town, or Location of Death 4c. County of Death more BaltimoRe TER MediCAL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 6 1 X M 2 🗆 Months Hours 215-24-5860 Director 82 1929 Maryland Usual Residence of Decedent 23a or 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 9103 Lincolnshire Ct #E 21234 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ŏ þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: white "natural", 45-56 Specify 3 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) filed within College (1-4 or 5+) 12 manager sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Ments John Francis Tress Sr Lucille Romaine Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Tress/spouse 9103 Lincolnshire Ct #E 27 Baltimore, MD 21234 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specif) Euneral Service Li Signature 22. Name and Address of Facility Anatomy Board 655 W. Baltimore Street nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) myozardia coron. Medical Due to (or as a consequence of) Examiner www Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit aspiration that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, s after death.
al Director: After th Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a

mulans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 NORTH GREENE ST. IABATAB 32. Registrar's

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P24524

State Registrar

only one) 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death ctober iles 201 Physician/ Medical County of Death ad lity Name (if not institution, give street and number) **Examiner** Himore cotons ville 7. Age (In yrs. last birthday) 75 Yrs. 8 Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Numbe **Funeral** Days Hours Mir Months 1 M M 2 - F Director 10c. City, 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Town or Location 10a. State 10b. County Funeral Director 1 Yes 2 No owynn 10g. Citizen of What Country? 10f. Zip Code 21207 Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No Yes, Give Completed by 1 Never Married 2 Married Black 1 Yes 2 No 21215-0036 Specify 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT usere fired) (Specify only highest grade completed) relay (0-12) College (1-4 or 5+) shove mar Be Morner's Name (First, Middle, Maiden Surr Baltimore, Maryland Name (First, Mildle, Last) 18. bodson hpt. 20 me/Relationship (Ty State, Zip Code) 19b. Mailing yon ware, 20b. Place of Disposition Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any legaling to immodiate Examine Due to or as a consequence of) cause. Enter Underlying -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last the burial-Physician/Medical Box 68760 attending physical for use as the l IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed I page 2 should be det ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 L Yes 1 Inpatient 2 I မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DWS 10 M.D 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN 21136

DHMH 17 Rev 7/2009

State Registrar CENTER

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Registrar's Signature

210

31. Date filed (Month, Day, Year) OCT 3 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:10 P M Physician/ 7011 Wright october Michael Medical give street and number) Facility Name (if not institution, **Examiner** Himore lusoice Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Unde **Funeral** 1 M 2 F Director 12-6-1958 52 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland **Funeral Director** 1 Yes 2 No Himore be notified MD -28a-f 10g. Citizen of What Country? ms 23a or 2 must be no USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygienen. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc Armed Forces? 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Completed by 1 🗆 Yes 2 🗷 No Specify. Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education sify only highest grade completed) (Give kind of work done during most of working ire, DO NOT use retired) dary (0-12) College (1-4 or 5+) Be r's Name (Ff9t, Middle, Maiden Sur ather's Name (First, Middle, Last) ပ္ State, Zip Code) t9h Mailing Ad MD 21133 Kanda Brothe Place of Disposition (Na 20a. Methed of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee C. Greene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final LUNG can (er Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to the condition of the conditions, if any leaf the conditions is a condition of the conditions of the co Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Records, P.O. Box 68760 as the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death page 2 should be detached for use 23b. Was decedent pregnant Ectopic pregnancy Year Month Day in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobabiy 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medica Division of Vital funeral director, Be Other: 4 Nursing Home 5 Residence 6 Dother Specify examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 No မ After this 28d. Describe how injury occurred 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MSRyapameM.D 10/26/11 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmone MO 21209

Registrar H DHMH 17 Rev 06-2011

State

S Rajapakte, M.D

31. Date filed (Month,

2835 Smin AV

32. Registrar's Signature

5 703

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 34616 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 24, 2011 Teresa Kay Ward 9:30 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F **Director** 57 Maryland 207-36-0664 Sept 19, 1954 Usual Residence of Decedent with the Maryland 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐Yes 2 ☐ No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Hospital Drive 20678 by Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Map Jones. Elementary/Secondary (0-12) carpentry College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Walker Ward ပ Alice Irene Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Dickerson/sister 9140 Southern MD Blvd Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Romald State Anatomy Board 655 W. Baltimore Street 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the control of the cont Approximate Interval Between Onset and Death Immediat aus (Final disease or c ition resulting in death) Atheroscienotic **Physician** Carchio vasu la relizease /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≨. mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Hemiplegia. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Hyperlipidemia performed? 1 □Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica filled in by the 24 hours a Funeral L

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 50653 29d. Date signed (Month, Day, Year) 10-25-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN . C. Churchton Road

Registrar

Medical

To the Within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death October 18, 2011 Physician/ 3:33 PM M McRae Whitaker Williams Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner **Baltimore** Owings Mills 2526 Caves Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 6. Sex **Funeral** 131-28-9506 Director 1 **X** M 2 □ F June 29, 1936 Maryland 75 Usual Residence of Deceden 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County 10a. State Director notified 1 ☐ Yes 2 🗓 No Owings Mills MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō must be USA 21117 2526 Caves Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced "natural" Completed er than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) healthcare 12 5+physician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental Fitem 27 is marked o မ Louisa Whitaker Palmer Francis Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1309\ Aintree\ Road\ Towson,\ MD\ 21286$ 19a. Informant's Name/Relationship (Type, Print) McRae W. Williams Jr/son other 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ö Department of Important; If any injury or once. 4 X Donation 5 Other (Specify) Sign ture Funeral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street mi 21201 MD<u>Baltimore.</u> 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Between shoo Onset and Death Immediate Cause (Final Ph sician/ CAR disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exam and burial-trar Hospital or Attending Physician. The law requires that the death certificate be execut
24 hours after death.
 Funeral Director. After this certificate has been signed by the attending physician and
etely filling in by the tuneral director, page 2 should be detached for use as the burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 No Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylar		artment of Health		lental Hy	giene		01.610
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	7		Reg. No. 4		34618
П	Physici			RANCES	AHALT		2. Date of De		Year 2011	3. Time of Death
acce.	Medi Exami		4a. Facility Name (if not institution, give street and number)	TANCES	4b. City, Town, or Locatio	n of Death	Octobe	4c. County		2:30 A M
			Frederick Memorial Hospital		Frederick	II OI DOGIII		1 .	leric	k.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. 213-14-9176) 6. Sex 7. Age (In yrs. 94			er 24 Hrs. Min.	8. Date of Birt	th	9. Birthp	lace (State or Foreign
	Director		213-14-9176 1 M 2 F 94  Usual Residence of Decedent	Yrs.	Months Days Flours	IVIIII.	2Mp71h999	7917	947	(Y)
	and show	٥		ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Frederick	Fre	ederick					1 🙀 Yes 2 □ No
	h the Baor	a D	10e. Street and Number		10f. Zip Code			10g. Citizen of V		try?
	ms 2; must	Funeral	206 Thomas Ave.		21701			U	SA	
(0	er dez or ite niner	Į.	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ❷ No	S.   13. V	Vas Decedent of Hispanic C f Yes, specify Cuban, Mexic	Origin? (Sper an, Puerto F	cify Yes or No- Rican, etc.)		e - America k, White, e	
03	ırs aftı ıral", LExar	Completed by	3 XWidowed 4 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 No Specifi	fy:		Specify:	Whi	te
5-0	2 hou "natu adica	plet	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupation kind of work done during mo	ast of working	ng.	16b. Kind of Bu	siness Inc	lustry
121	thin 7	l e	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	NOT use retired)  teller	JST OF WORKI	9	banki	na	
d 2	led w Hygir other ent, t	Be (	17. Father's Name (First, Middle, Last)			ther's Name	/Eirot Middle	Maiden Surname		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	Paul S. Rudy				Alice			
lan	should and N is me	0	19a. Informant's Name/Relationship (Type, Print) Dennis Ahalt (Son)	19b Majilia	g Address (Street and Num.	ber or Flural	Route Number	r, City or Town, S	ate Zip G	°¢9 <del>)</del> 7 7 1
ر. د	and 2 Health						, ML.	Airy,	MD Z	1//1
Jor	nt of h		1 By al 2 Cremation, 3 Removal from State 7.9	lace of Dispos	sition (Name of latory or other place) IN COMETERY	10/	ate 15/201	20c. Location -	City or Tov	wn, State
Ē	artme ortani injury		4 Donation 5 Dother Specify)  21 Ignature of Fire N Service Vensee							
Ba	lmp gany	7	HOV	22.	Dogram Address Faci	wnom] dd1⊖	oson F	uneral MD 217	Hom 69	e
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~	h sician/		Immediate Cause (Final disease or condition	tic		e De				Interval Between Onset and Death
	Medical Examiner		resulting in death)  Due to (or as a consequence)	uence of):	3/0/00	- 92	7		_	
		ē	Sequentially list conditions, b.							
	red nsit	Examiner	if any, leading to immediate Due to (or as a consequences. Enter Underlyin) Cause. Enter Underlyin Cause (Disease or iinjury	ience of):						
	execution and ial-tra	Exa	that initiated events c.  The sulting in death) Last c.  Due to (or as a consequence of the consequence of t	ience of):						
09	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d							
687	rtifical ing ph e as th	Med	IF FEMALE:							
Box	eath certifica attending pl	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregna	ıldeath 3 ∐	Ectopic pregnancy				of deliver	1
ŏ.	ne dez / the a ched f	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of c 9 ☐ Unknown 9 ☐ Unknown	eath 5 □	Other (specify)			Mon	th I	Day Year
P.0	Ine law requires that the de ate has been signed by the page 2 should be detached		Part II. Other significant conditions contributing to death but not res	ulting in the un	derlying cause given in Par	t I.	23e. Did tol	bacco use contri	oute to the	e cause of death?
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Records,	aw rec as bee 2 sho	plet	Congestive heart &	a. V.	en Tuo	VII	24a. Was a			sy findings available
, Re	rsician; The law is certificate has kiirector, page 2 s	Con	diahetes		17/		autops perfor	med? de	eath?	pletion of cause of
Vital	ician; sertific ector,	Be	25. Was case referred to medical examiner?  Hospital:		26. Place of De	ath (Check		2,310		
<u> </u>	rnysi this or	2	1 Inpatient 2	ER/Outpatient 28b. Time of				ence 6 🗌 Other		
0	th. After fune	Certificate:	1	injury	28c. Injury at work?  M 1  Yes 2		3d. Describe ho	ow injury occurred	1	
Division of	Attender dea ector: by the	ř.	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At homicide	me, farm, stree		-	Bf. Location (St	reet and Number	or Rural F	Route Number
<u>≥</u>	rs after al Din ed in		building, etc. (Specify)				City or Town			
	or brospinal or Attending Priysician; within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director,	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	edge, death oc	cured at the time, date and	place, and	due to the cau	se(s) and manner	as stated	
-	ithin 2  the lomple	Σ	only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	knowledge, de	ath occurred at the time, dat	e and place,	and due to the	cause(s) and man	ner as stat	ed.
<u> </u>	¥ ≥ ₽ 8			t m	29c. License number	70	2	9d. Date signed	Month, Da	ay, Year)
		-	30. Name and address of person who completed cause of death (Item	23a) (Type, Pri	nt)	18	2	Mole	110	72011
	0		HII Afradetek	300	west 9.	1/15	tree?	Fren	len	ck MD
	Stat	e	31. Date filed (Morto Car. Yari) 4 2011 32 Registrar's Signatu	ure la	Mal			1 00		
	Registra	r	1 minus	S. 149 CA	C3-4-0-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34619 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October 14, 2011 Physician/ 03:30 A M Ardis Leonard В. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Solomons Calvert Solomons Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 03707/1930 Virginia 227-34-3113 81 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location notified at Director 1 Yes 2 No Prince Frederick Maryland Calvert 10f. Zip Code 10g, Citizen of What Country? 9 10e. Street and Number Examiner must be 23a Funeral 20678 USA 318 Dew Drop Lane items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian. 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Private Industry Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ္ Nora Mason John Ardis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
318 Dew Drop Ln. Prince Frederick, MD 20678 19a. Informant's Name/Relationship (Type, Print) Christine Tenney (Step daughter) 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 10/18/2011 Brentwood, Maryland 22. Name and Address of Facility Rendon/Hale Funeral Homo 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 21. Signature 9013 Annapolis Rd. Lanham, Maryland 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerosis mmediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of): resulting in death) Last **burial**ending physician are use as the burial-Physician/Medical requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Year Month ρ Pregnant at time of death the a Unknown 9 Unknown P.O. as been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director. After this certificate has betted filled in by the funeral director, page 2 si performed? Yes 2 X 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \sum Yes 2 \textbf{X} No Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and October 14, 2011 D0031563 cause of death (Item 23a) (Type, Print)

0, 20945 Great Mills Rd #203 Lexington Park, MD 20653 Charles M. Benner, MD, Signature DCT 1 8 2011 State Registrar

			Please	Type or Print in Black In				•
			For State Registrar	State of Maryland / Depa	tificate of Death		ene eg. No. 2	31,620
	Physici		1. Decedent's Name (First, Middle, Las Judy Mallernee	t) Beatty		2. Date of Death October		3. Time of Death 7:20 p M
Z	Medi Exami		4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
-		,	Suburban Hospita  5. Social Security Number 6. Se		Bethesda If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgome	thplace (State or Foreign
	Funeral Director	ı		M 2 K F 68 Yrs.	Months Days Hours Min.	Nov. 2,	Year) 1942 Co	TN
	od at	١	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	//arylar Ba-f sl tiffed	recto	MD Montgon	nery Silve	r Spring			1 ☐ Yes 2X No
	a or 29	Funeral Director	10e. Street and Number		10f. Zip Code		ng. Citizen of What C	ountry?
	th with ms 23 must	nerg	9706 Marshall Av		20901		USA 14. Race - Ame	avion Indian
920	s after dea ral", or ite Examiner	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?	Vas Decedent of Hispanic Origin? (Spot Yes, specify Cuban, Mexican, Puerto  Yes 2 No Specify:	Rican, etc.)	Black, Whit Specify:	te. etc.
5-0	2 hour "natu	plete	15. Decedent's Ed (Specify only highest gra	de completed) (Give H	ent's Usual Occupation kind of work done during most of work	ing	16b. Kind of Business	Industry
121	ithin 7; ene. • than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	O NOT use retired) <b>cutive</b> Secretary		Banking	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Hugh Mallernee			ne (First, Middle, M Smith		
lary	should and M is ma auma		19a. Informant's Name/Relationship (Ty		g Address (Street and Number or Run			
e, R	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		Charles H. M. Be	20b. Place of Dispo	Marshall Avenue,		Spring, MD	
Baltimore,	age 1 ent of nt: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State cemetery, crem	aven Cemetery	ct. 20.	Silver Spr	
altir	mit. P partm portar y injur		21. Signature of Funeral Service Licens		Name and Address of Eacility rancis J.Collins 1 00 University Blv			
	Physician/ Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not enter	er the mode of dying, such as cardiac			ng, MD 20901 Approximate Interval Between Onset and Death
		xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b				
0	be executed sician and burial-transit	ш	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a consequence of):				
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burla-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  4  Pregnant at time of death 5  9 Unknown	Ectopic pregnancy Other (specify)		23d. Date of do	elivery Day Year
ls, P.O.	v requires that the destroyments been signed by the should be detached	ed by Ph	Part II. Other significant conditions co	ontributing to death but not resulting in the u	nderlying cause given in Part I.			o the cause of death?
of Vital Records,	The law require has bee bage 2 shou	Completed by				24a. Was an autops perform	ned? death?	utopsy findings available completion of cause of
tal	cian: 'certifica' ector, l	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Chec	k only one)		
j Vi	Physic this c	. To	1 Yes 2 No  27. Manner of Death	1 Inpatient 2 ER/Outpatien 28a. Date of injury 28b. Time of	t 3 🗆 DOA   4 🗀 Nursing H	ome 5 Reside	nce 6 Other (Spe w injury occurred	cify)
o uc	ath. r: Afte	icate	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		work? M 1 ☐ Yes 2 ☐ No			
Division	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	al Certificate;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specify)		City or Town,		
_	he Hospi iin 24 hou he Funera ipleted fille	Medical	(Check 2 Medical Exami	ician: To the best of my knowledge, death oner: On the basis of examination and/or invest e Practioner: To the best of my knowledge, oner:	igation, in my opinion, death occurred a	t the time, date and ce, and due to the	d place, and due to the cause(s) and manner a	s stated.
	م و م الم الم		29b. Signature and title of certifier	mo,mo	29c. License number 0 00 5 7/2		Ed. Date signed (Mon	

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) 0CT 17 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Truong Bao, MD 10110 Molecular Drive, #206, Rockville, MD 20850

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State		artment of Healt		ental Hygi	iene	34621
		Registrar  1. Decedent's Name (First, Middle, Last)	Ce	runcate or Death		2. Date of Death	eg. No. C 0 1 1	3. Time of Death
Physici Medi		Lisa B. Bordenick				Month October	Day 12, 2011	7:00a M
Exami		4a. Facility Name (if not institution, give street and number	r)	4b. City, Town, or Location			4c. County of Deat	
	P	Kline Hospice House  5. Social Security Number 6. Sex 7.	A co (lo use (oot birthdou)	Mt. Ai			Frede	
Funeral Director	П	579-54-5170 1 M 2 kg F	Age (In yrs. last birthday) 70 Yrs.	Months Days Hour		8. Date of Birth Sept 13	Year)1941 Was	thplace (State or Foreign hington, D.C
d d		Usual Residence of Decedent  10a. State 10b. County					, -, -, -, -, -, -, -, -, -, -, -, -, -,	
arylan a-f sh fied a	ecto	Maryland   Frederick	10c. City, Town or Lo					10d. Inside City Limits  XX Yes 2 □ No
the M or 28 e noti	Ē	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What Co	
n with	<b>Funeral Director</b>	2505 Bear Den Road		21701	L		USA	<b>,</b>
r item	F	11. Marital Status 12. Was Deceder Armed Force	s?	Was Decedent of Hispanic	Origin? (Specifican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
036 s after ral", o Exam	d by	1 Never Married 2XXMarried 1 Yes 22 If Yes, Give Year or Dates	<b>€</b> No	1 ☐ Yes 2XXXNo Spec			Specify:	white
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121 thin 7	Completed	Elementary/Seconday (0-12) 5+ College (1-4 co		kind of work done during m O NOT use retired) • her	nost of working		Education	
Id 2	Be (	17. Father's Name (First, Middle, Last)	1200		other's Name (F	First, Middle, Ma		
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	욘	Louis Brisker		S	Sarah F	ranklin		
ore, Maryla e 1 and 2 should be t of Health and Men if item 27 is marke	S	19a. Informant's Name/Relationship (Type, Print)  Bernard Bordenick - husbar	nd 2505	ng Address (Street and Nun Bear Den Ro	mber or Rural R Dad, Fre	Route Number C ederick	City or Town, State, Zig Mary Land	Code) 21701
Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", o mynipury or other traumatic event, the Medical Exam		20a. Method of Disposition	20b. Place of Dispo cemetery, crer Garden of	esition (Name of matory or other place)  Remembrance	Dat 10-14		Oc. Location - City or	
Baltimol permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licenses	22	2. Name and Address of Factors 21 Opossumto	i <sup>icility</sup> Sta	uffer F	uneral Hom	e
		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I	sed the death. Do not ente	er the mode of dying, such	as cardiac or re	espiratory arrest	t,	Approximate
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res tha	d by	Part II. Other significant conditions contributing to death  malignary pleure effect		nderlying cause given in Pa	art I.		cco use contribute to	the cause of death?
COLGS, aw requires as been sig	lete					24a. Was an		
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Completed					autopsy performe	prior to c death?	opsy findings available ompletion of cause of
ian: T		25. Was case referred to medical examiner?			eath (Check on			2 🗌 No
Physic this ce	욛	1 ☐ Yes 2 ☑ No Hospital:	itient 2 ER/Outpatien	t 3 DOA Other: 4 D	Nursing Home	5 Residence	ce 6 Other (Specia	y) (hospice).
ding P ding P th. After t funera	Certificate:	27. Manner of Death  1 Natural 5 Pending (Month, D		28c. Injury at work?	28d	f. Describe how	injury occurred	,
Atten ar deal ector: by the	<u> </u>	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Ir	njury - At home, farm, stre	M 1 ☐ Yes 2		. Location (Stree	et and Number or Rura	al Boute Number
ital or ral Direction		building, e	tc. (Specify)			City or Town, S		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or investi	gation, in my opinion, death	occurred at the	time date and r	place and due to the ca	ause(s) and manner stated
To t	— г	29b. Signature and title of certifier		29c. License number	r	290	d. Date signed (Month,	
	-	In those		000676	571	1	0-13-11	
10		30. Name and address of person who completed cause of Main G. Geldstein, カカ	501 W S.	venth St.,	Frede	rich, 1	TD 2170	,
State Registra	1	31. Date filed (Month, Day, Year) 32 Regist	rar's Signature	rkel		·		
110913112		VVI A L MAIN	Jed Selection	7.70				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 11. Grace Ellen Bush 201 Tear 5:50 a. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Mt. Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🕱 F 69  $\lim_{n \to \infty} 3$ , Year) 42 218-40-3904 Director Pennsylvania Yrs June Usual Residence of Decedent 28a-f shov 10a. State with the Maryland notified at 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits Woodsboro Maryland Frederick 1 🗆 Yes 2 🗷 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 104 Woodbury Drive 21798 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes ऋ文 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever 2 Grace Chipley William E. Hartsough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Carol Tressler / Daughter 104 Woodbury Dr., Woodsboro, MD 21798 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 😾 Cremation 3 🗆 Removal from State 10/13/2011 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21704 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Weeks Medical resulting in death) Due to (or a / a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atte in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Nonknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 \sum No 2 🗌 No 1 Yes hours after death.

Ineral Director: After this certific
d filled in by the funeral director, To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) <del>Hospice</del> Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec House 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ino N Kanan Hus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nomas 20 hymon 200 32 Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 12, 2011 9:16 A M C. JOHN **BYRD** 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 30019 Hudson Corner Road Marion Station Somerset If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 XM 2 ☐ F 215-20-2038 11/09/1928 Maryland 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Crisfield Somerset 10g. Citizen of What Country? 10e. Street and Number 4131 Jacksonville Road 21817 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☑Yes 2 ☐ No 1951 — If Yes, Give Year or Dates: 1994 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 1994 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Merrill Byrd Ella Marie Hartman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4131 Jacksonville Road - Crisfield, MD 21817 Ruby Byrd (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Sunnyridge Mem. Park | 10/15/2011 Crisfield, MD 21. Signature of Funeral Service Lieusee Robert H. Bradshaw, Tr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati Due to (or as a consequence of): Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? g to death but not resulting in the underlying cause given in Part I

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

by Funeral

Completed

Be

mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla authment of Heatth and Mental Hygiene. ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinant to indiffice at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Box 68760.

P.O.

Records,

and burial-trar attending physician for use as the buria signed by t icate has been si certificate funeral director, this After t

Physician/Medical δ Completed Be Certification: To

Medical

untite 31. Date filed (Month, Day,

Division of Vital To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions/contain 1 ☐ Yes 2 ☐ No 3 ☐ Probably VINknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops: perform 2 No tes 1 ☐ Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifyi hg 🚧 ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso WINTERPLACE PK SUITE 103 SALISBURY NOD

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verb., g920, 10/31/2011 dhb
Certificate of Death
Reg. No. Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month BILLY LEE BELOTE 10:09 a<sup>M</sup> Medical Oct. 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Worcester 2050 Wildwood Trail Pocomoke City Social Security Number Sex 1 M 2 D F . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min 11/2571930 Director 229-36-4954 80 Virginia Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Virginia Accomack Ouinby 1X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20039 Quinby Bridge Road 23423 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes Year or Dates.1949-51 1 ☐ Yes 2 👿 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) mechanic automotive 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ೭ William Lee Belote Marion Lee Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 184, Quinby, Virginia 23423 Margaret M. Belote / wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Wachapreague Cemetery 10/20/2011 Wachapreague, Virginia 5 Other (Specify) 4 Donation 21. Signature Funeral Service License 22. Name and Address of Facility P. O. Box 633 Doughty Funeral Home Exmore, VA 23350 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. 23a, Part Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to for as a nonsequence of or cause. Enter Underlying Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death
Unknown Month Yes 2 No signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? certificate Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Residence ဂ္ 1 Yes Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify, this eral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34625 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ber Physician/ 1050 M 2011 Bertie Estelle Chance Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico teninsula Regional medical conter Salisbur 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under **Funeral** Director 1 🗆 M 2 😾 F 90 VA March 12,1921 show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No VA Accomack Saxis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20214 Saxis Road 23427 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married Yes Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: "natural" White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Clark Mary Ellis other traumatic and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 111 Fountain Drive, York, PA 17402 <u> Vivian Bailey - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Temperanceville, 2011 Taylor Cemetery Oct. 15 John W. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Thornton Funeral Home, Inc. sall 24183 Chadbourne St., Parksley, VA 23421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial Physician/Medical certificate be Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown signed by the g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy perform death? After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 2X No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury Accident Investigation within 24 hours after deat To the Funeral Director: completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ed cause of death (Item 23a) (Type, Print) 100 E Carroll Street Salisbur Q mueller, MD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Magdalena Canlas 10775/2011 G. 12:36 P™ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9404 Shallow Creek Lane Ft. Washington Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 577-04-2310 82 Philippines Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No Maryland Prince George's Ft. Washington 10e. Street and Number 10g. Citizen of What Country? 9404 Shallow Creek Lane 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify: Filipino 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gumabon Mercedes Santos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernesto G. Canlas Jr. Son 12919 Asbury Dr. Ft. Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 10/22/2011 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signature Juneral Service Lixturee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of):

Physician/ Medical **Examiner** 

been signed by the attending physician and should be detached for use as the burial-transit

has

eral Director: After filled in by the funer

within 24 hours To the Funeral

or Attending Physician; The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Physician/

Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show notified at

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Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho

of Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me

- 5

Department of Important: If any injury or

Maryland 21215-0036

Baltimore,

Examiner Certificate: To Be Completed by Physician/Medical IF FEMALE: 9 🗌 Unknown

23b. Was decedent pregnant in the past 12 months?
1 Yes 2XX No

Live Birth 2 Fetal death Pregnant at time of death

23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) Month

perform

Yes 2 XXVo

20774

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical Hospital: 1 🗌 Yes 2XXNo 27. Manner of Death 1 X Natural 5 Pending Investigation

2 Accident Suicide

4 Homicide

Date filed (Month, Day

OCT 1 8 2011

29a. Certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) work? 1 \(\sime\) Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and

6 Could not be

determined

10102

Other:

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print ma MD 9200 Basil Court #2 Zama

9200 Basil Court #200 Largo, Maryland

State Registrar

Medical

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Baptist Vincent Capuccio D555 October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elkton Care & Rehabilitation Center E1kton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Oct. 6, 1 ፟ M 2 □ F Months 0ays Hours Min. New York 068-10-3434 **Director** 94 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 83 Clearview Avenue 21901 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 😾 Widowed 4 🗆 Divorced Specify: White Completed 15. Decedent's Education <sup>16b.</sup> Kind of Business Industry New York City Dept. of Parks 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Twelve Years Foreman New York, New York Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Capuccio Lena Prignano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 83 Clearview Avenue, North East, Maryland Salvatore Capuccio (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place).
North East Methodist 20c. Location - City or Town, State 1 🖔 Burial 2 □ Cremation 3 □ Removal from State 10/21/11 4 Donation 5 Other (Specify) North East, Maryland Cemetery 21. Signature of Funeral Service Lice <sup>22</sup> Name and Address of Facility on & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. ediate Cause (Final ase or condition Immediate Cause (Final Physician/ years disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed's 2 X No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and tipp of certifier 10.18.2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S & CHDEV MD 126 A, E H Elpin MD 21921 32. Registrar's Signatur State Registrar

State Registrar

Box 68760

P.O.

1500 Forest Glen Road, Silver Spring, MD 20910

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Irina Kuban, MD

17 2011

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 17 201<sup>res</sup> WILLIAM L. EWING, SR. 04:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CECIL 265 STARKEY LANE ELKTON 6. Sex 1 XM 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign Country NORTH EAST MARY LAND 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours APRIL 21 217-16-7233 Director 88 Usual Residence of Decedent shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f s 1 Tyes 2 No MARYLAND CECIL ELKTON 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 265 STARKEY LANE UNITED STATES 21921 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces?

1 X Yes 2 No "natural", or 1 Never Married 2 Married <u>Ş</u> ARMY Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates.1943-45 Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 MUNITIONS X-RAY TECHNICIAN GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental P ပ္ permit. Page 1 and 2 should be Department of Health and Ment. Important; If item 27 is marked any injury or com. DANIEL LEON EWING MAMMIE DENNISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD F. EWING / SON SALUATION CIRCLE, NORTH EAST, MARYLAND 2190 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State cemetery, crematory or other place. OCTOBER 21, 1 X Burial 2 Cremation 3 Removal from State NORTH FAST CHNITERY NORTH EAST, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) T'CHMETERY 2011 NORTH EAST, MA
22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 21. Signature ) Funcial Service in ensee 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final Myo cardicel Onset and Death Ph sician/ disease or condition resulting in death) Medical **Examiner** onary Sequentially list conditions dequentially list condition than, leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a surrouguence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1. ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 K 2 × No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

/OctIVA

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# | perphys. G948 . 2/27/2014 WS

			For State	State of Marylan				Mental Hyg	giene	
			Registrar	Notalia Alva		tificate of D	eath	2. Date of Dea	Reg. No. 20	1 34630
	Physicia Medi		1. Decedent's Name (First, Middle, Last)   Natalia		rado De	riores			11 p2011 Y	10:30a <sub>M</sub>
	Examir	ner	4a. Facility Name (if not institution, give stre 712 Douglas Av			4b. City, Town, or Rocks		ith	4c. County of Mon	tgomery
	Funeral Director		5. Social Security Number 219-94-8505  Usual Residence of Decedent	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			Birthplace (State or Foreign Country) Salvador
	aryland a <b>-f shov</b> fied at	ector	10a. State 10b. County MD Montgome		y, Town or Loc					10d. Inside City Limits 1 ★ Yes 2 □ No
	th the Manager 198	Funeral Director	10e. Street and Number 712 Douglas Aver			10f. Zip Code	0852		10g. Citizen of Wha	at Country?
926	ye 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ρ		Was Decedent Ever in U.S Armed Forces? 1 Yes 2 Xo If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cubar	spanic Origin? (	Specify Yes or No- to Rican, etc.) Vadoran	14. Race - A	American Indian, White, etc. White
21215-0036	ithin 72 houn iene. r than "natur the Medical	Completed	15. Decedent's Educa (Specify only highest grade selementary/Secondary (0-12)	ation	(Give k life. DC	ent's Usual Occupa ind of work done do NOT use retired) Omemaker	uring most of w	orking	16b. Kind of Busin	,
Maryland 2	should be filed within and Mental Hygiene. is marked other tha 'aumatic event, the N	To Be	17. Father's Name (First, Middle, Last) Silvestre Alva:	rado			18. Mother's Na	ame (First, Middle, 1 a Bonill	Maiden Surname)	
	12 shoul		19a. Informant's Name/Relationship (Type, Roberto Flores/		1				City or Town, State	
Baltimore,	age 1 and ant of Hea t: If item / or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Re	noval from State	lace of Dispos	sition (Name of latory or other place Heaver	1	Date	20c. Location - Cit	
Baltir	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Transce	12						ICE,P.A. ing,Md20910
ľ			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complete the complete shock and	tions that caused the death		• •				Approximate Interval Between
	Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Metasta		ryoid c	ancer			Onset and Death 30mo.
		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of):					
	cate be executed physician and sthe burial transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
092	cate be e physicia s the bur	edical	d.							
. Box 68760	that the death certific ned by the attending p edetached for use as	∑	IF FEMALE: 23b. Was decedent pregnant 23c in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of pregnal 1 Live Birth 2 Feta 4 Pregnant at time of d	Ideath 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date o Month	f delivery Day Year
, P.O.		þ	Part II. Other significant conditions contri	buting to death but not res	ulting in the ur	nderlying cause give	en in Part I.			te to the cause of death?
ords	w requires that s been signed b 2 should be det	Completed						24a. Was a	n 24b. Wen	Probably 4 Unknown
l Rec	sician: The law is certificate has k		25. Was case referred to medical			00 51-		autop: perfor 1  Yes	med? deat	r to completion of cause of th? Yes 2 \( \sum \text{No} \)
Vita	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 🔀 No	pital:	ER/Outpatient	Othor	ce of Death (Chi		ence 6 🗆 Other (S	Specify)
on of	ath. t After the funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🔲	at		ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division of Vital Records,	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign gempletely filled in by the funeral director, page 2 should be	al Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (Si City or Town		r Rural Route Number,
	ne Hospi in 24 hou se Funer pletely fil.	Medical	(Check 2 Medical Examiner:	n: To the best of my knowled On the basis of examination ractitioner: To the best of m	and/or investi	gation, in my opinior	n, death occurred	l at the time, date ar	nd place, and due to	the cause(s) and manner stated.
	withi To th		29b. Signature and title of certifier	Dha	W	29c. License D3	number 3224	2	Oct.12	
			30. Name and address of person who comp Ram Trehan M.I	oleted cause of death (Item 0 • 1400 Fo	23a) (Type, Pr	Glen Rd	l #435	Silver	Spring,	Md 20910
ı	Stat Registra		31. Date filed (Month, Day, Year)  OCT 1 7 2011	32. Registrar's Signat	ure face	W.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Year Physician/ Day 12:15P M 11 William Feller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Min. 1 🔀 M 2 🗆 F Hours (Month Day Year) Director Yrs 96 578-12-0346 Usual Residence of Deceden 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director must be notified 1 Yes 2 No MD Bethesda Montgomery 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral filed within 72 hours after death with 20816 U.S.A. 5101 Ridgefield Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Department Director Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ pe Fannie Glass t. Page 1 and 2 should by thent of Health and Mer tant; If item 27 is mark Morris Feller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37101 S. Golf Course Dr., Tucson, AZ 85739 Ronald R. Feller - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Donation 5 Other (Co. M.) Removal from State 20c. Location - City or Town, State Department of Important: If it any injury or c Donation 5 Other (Specify) King David Memorial 10/12/2011 Falls Church, VA Signature of Funeral Service Licensee 22. Name and Address of Facility mary National Funeral Home 7482 Lee Hwy., Falls Church, VA 22042 Holden 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Aspiration Pneumonia Medical Due to (or as a consequence of) Examiner Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): g physician and as the burial-transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as i attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ ģ in the past 12 months? Day Pregnant at time of death Yes 2 No ed by the 9 Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed?
1 Yes 2 No certificate 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\blacksquare$  Other (Specify) Hospice 2 🖾 No 1 Tyes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work' vithin 24 hours after death.

To the Funeral Director: All completed filled in by the fu М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 10 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37142 10/11/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar G. Coleman, M. ID.

31. Date filed (Month, Day, Year,

1355 Piccard Drive; Rockville,MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34632 1-Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Oct 21, 2011 **Physician** Green Kathryn 3:20 AM<sup>™</sup> Thalia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Golden Living Center Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 7, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country NY **Funeral** <sup>Year)</sup> 1916 1 □ M 2 □**X** Days Hours Min 220-10-7391 95 Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location show traumatic event, the Medical Examinar must be notified at Mineral Ridgeley Director 1 ☐ Yes 2 ☐ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö Rt. 4 Box 177 26753 USA items 23a Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married JO. Baltimore, Maryland 21215-0036 1 □Yes 2 ☐No Specify þ Specify: 3 → Widowed 4 □ Divorced white "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles B. Wonders Homie L. Schoonover 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ridgelev WV 26753 Informant's Name/Relationship (Type. Print)
Barbara Snyder Ridgeley niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date nlace) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 10/22/2011 MD Cresaptown 4 ☐ Demation 5 ☐ Other (\$pecify) Funeral Service Licensee 22. Name as Addres In Funeral Home, PA 21. Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Discorse Immediate Cause (Final COYUNEL VVI **Physician** 10 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate perform 2.2 No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No William Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dir 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title bi certifier 29d. Date signed (Month, Day, Year) 29c. License number ٩ 2011 D00332F6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

625 Kert Aye. Ste. 101 Cumberland, MD 31502

Paul Gleditsch, Jr

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certific	cate of	Death			Re	∋g. No.		•	0 1000
Physici edical Exam	ian/ iner	1. Decedent's Name (First, Mid-	B •	G1	editsc	h				Date of Deat Month October 4	Day	Year	1	of Death 9 hrs
		4a. Facility Name (if not instituti Meritus Medical Cent		et and numb	er)	4	b. City, Town, or Hagerstown		f Death			ounty of Dea		
Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs, last b	oirthday)	If Under 1 Year	If Under	r 24Hrs.	8. Date of Bir	th (MM/DD/	YYYY) 9. I	Birthplace (	State or
Director		181-44-4613	1 X M	2 F	57	Yrs.	Months Days	Hours	Min.	10/18	3/195	3 For	reign Country)	PA.
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. teath and Mental Hygiene. traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent  10a. State CO 10b. County Doug  10e. Street and Number 16202 Parks  11. Marital Status 1 Never Married 2	glas ide D	Was Decede	ent Ever in U.S.	arkeı		panic Orig		ify Yes or No		USA Race - Am White, etc.	ountry?	
5-0036 led within 72 hours after de Hygiene. other than "natural", or the Medical Examiner m	ted by	3 Widowed 4 Di 15. Decedent's Education (Sp Elementary/Secondary (0-12	ecify only his	ates:		a. Decedent	Yes 2 No Susual Occupatest of working life.	on (Give k	use retired		16b. Kind Den	ecify: of Busines	ss/Industry Flow	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	E	17. Father's Name (First, Middle	e, Last)							irst, Middle, N				
be file ontal Hyerry	Be	Paul L.Gled				Continue to				Mille				1000
MD 21 d 2 should th and Me n 27 is ma	٩	Donna Gleditsch/Wife 16202 Parkside Drive Parker, Color												
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. Department of Health and Mental Hygienic Important: If tiem 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition  1 X Burial 2 Cremation 3 X Removal from State  4 Donation 5 Other Specify  Round Hill Cem. 10/10/2011 Elizabe												PA.
Ball permit Depart Impor		21. Signatur of Funeral Service Life see  22. Name and Address of Facility Gilbert Funeral Ho Crematory Inc. 6028 Smithfield S												and oston,
Physician		23a. Part I. Enter the disease, of failure. List only one caus	r complication on each lin	ons that caus ne.	ed the death. Do	not enter th	e mode of dying,	such as ca	ardiac or re	espiratory arre	est, shock,	or hea <b>r</b> t		en Onset and Death
≥xaminer	n/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. ACute Myocardial Infarct  Due to (or as a consequence of):  b. Acute Coronary Artery Thrombus  Due to (or as a consequence of):  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):												
760, cate be executed physician and he burial - transit	dical	UNPENDED	d	MENDED									+-	
lox 687 eath certificate attending	Physician/Me		the 1 1 1 1 1 1 1 1 1 1	Live birth Pregnant	at time of death	2 Feta	aideath 3 [ er (S <i>pecify)</i> _	Ectopic	pregnanc		Mor		Day	Year
ires that the d signed by the	ě	Part ii. Other significant cond	itions conf	tributing to de	eath but not result	ing in the ur	nderlying cause g	iven in Par	rt I.		_			e of death?  Unknown
Records, The law require ficate has been si, page 2 should by	Completed									24a. Was autop perfor	sy med?		to completic ?	dings available on of cause of
Vital Reysiciae: The his certificate director, page	BeC	25. Was case referred to medic examiner?							Check onl	y one)				
F Vit Physic r this c	일	1 ✓ Yes 2 No	Hospit	1   11   11   10		/Outpatient				Home 5			her:	
D vision of Vital tall or Attending Physiciso is after deat.  al lirector After this certiled in by the funeral director	28a. Date of injury 28b. Time of injury 28c. Injury at Work? 28b. Describe now injury occurred (Month, Day, Year)													
D VISI	27. Matural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 20. Configure 20. Date of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 287. Location (Street and Number or or Town, State)										Rural Route	e Number, City		
the the	Medical C	29a. Certifier 1 Certifying I Check only 1 Medical Ex	aminer:On t	the basis of e	f my knowledge, dexamination and/or									s)
	Me	29b Signature and title of certif		manner state	su	_	29c. Licens	e number			29d. Date	e signed (M	Month, Day,	Year)
30		Har Un	٢	200	d s		0.0.1	M.E.			Octobe	er 5, 201	1	
		30. Name and address of perso Patricia Aronica-Polla	100_		of death (Item 23a t Medical Exa	•	900 W. Baltin	nore Str	eet. Bal	timore. MI	D 21223			
	tate	31. Date filed (Month, Pay, Year		32. Regis	strar's Signature	Lau			,					
Regis	ग्राह्म		-011	Krist	un p.	149 644	-							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ October 9 Clyde Grayson Grubb 7:53 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Edenton Retirement Community Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 🕱 M 2 🗆 F Hours Maryland Director 577-03-8682 Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 5800 Genesis Lane 10f. Zip Code 21703 10g. Citizen of What Country?
United States "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by Black White etc 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working e 1 and 2 should be filed within 72 tof Health and Mental Hygiene. If item 27 is marked other than 'or other traumatic event, the Me life. DO NOT use retired) atal Hygiene. ed other thar event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Printing Executive Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ George Clyde Grubb Daisy Lee Mossburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Wells, Jr./Grandson 13405 John Cline Rd. Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or other 20c. Location - City or Town, State Page 1 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State Resthaven Crematory 4 Donation 5 Other (Specify) Frederick, MD Signature of Funeral Service Licensee 2 Name and Address of Facility Rest haven funeral services Skkot Cody 2P7 A 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the diseas 1, o ct implications that caused shock, or heart failure. I in only one cause on each line of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyopathy Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? prostate cancer Division of Vital Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 2 No death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2**X X**No ျှ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence of Other Specific Living 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) U21936 lon 10-10-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNSON DC. FREDERICE MO 65C THUM 45 A. DUNELSON, MD

Registrar

State

31. Date filed (Monto

32, Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	e Type or Pr State of M		d / Depa	artmen	t of H	lealth :				Legible	).	
		State Registrar	anti		Cei	tificate	e of D	eath			Reg. No.	201	1 3	4635
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Examin	er	4a. Facility Name (if not institution, giv			100	4b. City,	Town, or	Location of				County of De		
Funeral		Fennsula tragional 5. Social Security Number 6.	Sex 7. A	ge (In yrs. la	ast birthday)	If Under		If Under	24 Hrs.	8. Date of Birtl	1		irthplace (Sta	ite or Foreign
Director		- 1 7 32 3301	1 □ M 2 🕱 F	53	Yrs.	Months	Days	Hours	Min.	(Month, Day 01/29/			ou <i>ntry)</i> nsylva	nia
show dat	ŏ	Usual Residence of Decedent  10a. State  10b. County		10c. City	y, Town or Lo	cation							10d. Insid	e City Limits
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th with the Maryland ms 23a or 28a-f sho must be notified at	<u>=</u>	10e. Street and Number				10f. Zip					10g. Citiz	zen of What C	Country?	
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er dez or ite miner	by F	1 Never Married 2 X Married	Armed Forces	?		f Yes, spec	ify Cubar	n, Mexicar	n, Puerto	Rican, etc.)		14. Race - Am Black, Wh	ite, etc.	la.
2 hours after death v "natural", or items edical Examiner mu	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			I ☐ Yes	2 <b>X</b> No	Specify:			5	Specify: Wh	iite	
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uld be I Ment narke	욘	Lewis B. Smith			1			Elea	anor	Guest				
2 shot th and 27 is n traum		19a. Informant's Name/Relationship ( Gary G. Gerald (			1	0	,			Route Number				21020
f and f Heal item other		20a. Method of Disposition			lace of Dispo	sition (Nam	ne of			oad-Mari		cation - City of	·	
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Dhusisian/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.	1	,			cardiac o	r respiratory am	est,			imate Between and Death
Physician/ Medical		disease or condition resulting in death)	a. Intro			40rM	agc	,						
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tth cer ttendii for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Feta	ldeath 3	Ectopic p		у			2	23d. Date of d	lelivery Day	Year
y the a	)Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown		leath 5 L	Other (sp	ecify)					WIGHT	Day	real
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quires en sig ould b	ted									1 🗆 1	'es 2 [	□ No 3 □	Probably 4	Unknown
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tendii death. tor: Al	Certificate:	2 Accident Investigation 3 Suicide 6 Could not	on be			M	1 🗆 '	Yes 2						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best o	of my knowle	edge, death	occurred at	the time	, date and	place, ar	nd due to the ca	use(s) an	d manner as	stated.	
the Ho hin 24 the Fu		only one) 3 Certifying Nu	niner: On the basis of rse Practitioner: To the	examination	and/or inves	tigation, in n	ny opinio	n, death oc	ccurred at	the time, date a	nd place,	and due to the	e cause(s) and	I manner stated
or viit		29b. Signature and title of certifier	ayes	Í		29c.	License	number			29d. Date	e signed (Mor		)
XLA	-	30. Name and address of person who		death (Itam	23a) /Typo - F	Print)	10	100			/	0 11	2011	
		Gayatri So	nt MC		00 E	Carr	011 S	treet	- Sa	lis bun,	nul	718	01	
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DHMH 17 Rev 06-2011

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neral		St. Catherine' 5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Yea		Hrs. 8. Date of Bi	Frederick  8. Date of Birth  9. Birthplace (State of Birth)					
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De no	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?					
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or lie	/ Fur	1 ☐ Never Married 2 ☐ Mai	Armed Fo	rces? 2 XNo		If Yes, specify Cu 1 ☐ Yes 2 X N	ıban, Mexican, F	Puerto Rican, etc.)	Bla	ack, White, etc.  ify: White				
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imporant: It ten 27 is market other trian includar, on tems 25a or 26a-1 show any injury or other traumatic event, the Medical Exercitor must be nothing at once.	Be	17. Father's Name (First, Middle						Name (First, Middle		ame)				
umatic	으	Beverly Lux Go  19a. Informant's Name/Relations		1	19b. Maili	ng Address (Stre		nor Morri		n, State, Zip Code)				
er trai		Ann Eicher / D	aughter		10343	Foxlei	gh Circ]	le, Waynes	sboro, P	PA 17268				
or oth		20a. Method of Disposition 1 ☐ Burial 2 🗓 Cremation	3 Removal from	State	lace of Dispo emetery, cre	osition (Name of matory or other p	lace) Oc	tober 23,	20c. Location	n - City or Town, State	,			
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any		M M	L.	MO14				ord PA Fu		ome , MD_21701				
		23a. Part . Enter the disease of shock, or heart failure. Lis	r complications that only one cause on	aused the death						Approximate Interval Betwe				
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or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live I	come of pregna	death 3	⊒ Ectopic pregna			1	Date of delivery Month Day Yea	ar			
ched	Physician/Medical	1 □Yes 2 No 9 □ Unknown	4 ∐ Pregi 9 ∐ Unkn	nant at time of d own	eath 5[	Other (specify)			-					
as boon signed by the arestoning prystician and 2 should be detached for use as the burial-transit	y Pr	Part II Other significant condit	ions contributing to de	eath but not resu	liting in the u	inderlying cause	given in Part I.	23e. Did	e. Did tobacco use contribute to the cause of death?					
d bluo	Completed by	Jusulin	Depend	end L	July	etts N	Ullit	<u>us</u> 10	Yes 2 No	3 Probably 4 Uni	known			
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or, pag	e Co	performed?   death?												
direct	8	examiner? 1 ☐ Yes 2 ☑ No		Inpatient 2 🗆	ER/Outpatie	nt 3 □ DOA				Other (Specify)				
neral d	. T.	27. Manner of Death  1 X Natural 5 ☐ Pendi	Hospital: 1 □						5 Residence 6 Other (Specify)  Describe how injury occurred					
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completely filled in by the funeral director, page	Medical Certification	2 Accident invest 3 Suicide 6 Could 4 Homicide detern  29a. Certifier (Check only Check only Medica	28a. Date (Mon igation not be mined 28e. Place buildi ing Physician: To the I Examiner: On the band man	of Injury - At hong, etc. (Specified best of my knowasis of examina	Injury ome, farm, st y) wledge, dea	M 1  reet, factory, offic  th occurred at the nivestigation, in m  29c. Lice	fork? Yes 2 No	28f. Location City or To place, and due to the occurred at the time	e cause(s) and	manner as stated.	);;			

101 State Registrar

DHMH 17 Rev 1/2001

Emmitsburg

MD 21727

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Carrol MD 310 S. Seton Ave

31. Date filed (Month, Day, Year)

32 Registrat's Signature

Alan Carroll MI
31. Date filed (Month, Day, Year)

OCT 31 2011

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

62. Registrar's Signature

Nicole Christenson, CRNP

31. Date filed (Month, Day, Year,

29c. License number

R120698

1355 Piccard Drive, Rockville, MD 20850

29d. Date signed (Month. Dav. Year)

October 15, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 MELVIN October 3:30 Medical HANSON 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 X Months Days Hours Feb. 23, Year 923 Director South Dakota 488-22-6591 88 Usual Residence of Decedent show 10a. State 10b. County 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Yes 2 No Frederick Maryland Frederick 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21702 United States 862 Waterford Drive r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No WWII If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 8 Foreman Caterpillar other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) (unk) 17. Father's Name (First, Middle, Last) (unk) marked ပ္ N/A 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State .8 permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra 862 Waterford Dr., Frederick, MD 21702 Aaron Hanson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2011 Mt. Olivet Cemetery Frederick, Maryland 21. Sign e of Funeral Service Licen Stauffer Funeral Bome 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Path. Enter the diseat lock, or heart failure t, or complications that care ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on fact line. Approximate Interval Between Immediate Cause (Fin Physician/ Onset and Death PHEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami and -transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No ပ္ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident Investigation 1 Yes 2 No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 10 MDD71068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sathyabama Naiduimo

State

Registrar

31. Date filed (Month, Day, Year)

OCT

1

400 W

Registrar's Signature

7th 3+

Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 7, 2011 Wilma Handon-Wright 8:38 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hyattsville Independence Court of Hyattsville 8. Date of Birth Ap**Mo1**th Dalk **9**ear) 1936 9. Birthplace (State or Foreign Country) DC If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🄀 F Hours **Director** 578-48-0682 75 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural" actions on ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville 1 🖺 Yes 2 🗌 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 20782 5821 Queens Chapel Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. African 0. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: If Yes, Give Year or Dates 3 Midowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. d other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DC Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men-Ing ortant: If item 27 is marke any injury or other traumatic. once. George Handon traumatic Monnie Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Esther Walker - Sister 1218 Irving Street NE Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Suitland, Maryland of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Endstage Renal Disease Medical resulting in death) **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertention Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Be Completed by Physician/Medical Failure To Thrive Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Late Effect of Stroke 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Dialysis Dependent, Renal Failure s certificate has birector, page 2 s 24a. Was an autopsy performed Yes 2 death? Decubitus Ulcers 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ XOther (Specify) Certificate: To 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. ☐ Accident ☐ Suicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: The basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signat 29c. License number D0057042 and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane Largo, Maryland Anita K. Clayton MD 20772

DHMH 17 Rev 7/2009

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 _ State	partment of Health and Nertificate of Death	, ,	201	1 21610		
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Deat	eg. No.	3. Time of Death		
	Physicia Medic		Edith Wonneta Jack		Month October	Day Year 2011	5:27 A M		
	Examin		4a. Facility Name (if not institution, give street and number) Dennett Road Manor	4b. City, Town, or Location of Death		4c. County of Dea			
			1113 Mary Drive	Oakland		Garrett			
	Funeral Director		5. Social Security Number    214-16-2692	Months Days Hours Min	8. Date of Birth (Month, Day, 18/19		thplace (State or Foreign ountry) Lland, MD		
	- A		Usual Residence of Decedent		7/10/19	19   Oak	Tand, MD		
	yland f sho ed at	tor	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits		
	e Mar r 28a- notifii	Director	MD Garrett Oakland	Transfer of			1 🗌 Yes 2 🖾 No		
	ith th		17659 Garrett Hwy.	10f. Zip Code 21550	1	I0g. Citizen of What C	ountry?		
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	erican Indian		
2	fter de	þ	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.		
2	urs at tural" al Exa	ted	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛛 No Specify:		Specify: W	nite		
ξ	72 ho n "na fledio	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Git	cedent's Usual Occupation ve kind of work done during most of workii . DO NOT use retired)	ng	16b. Kind of Business	Industry		
21215-0036	vithin liene.	Co	Elementary/Seconday (0-12) College (1-4 or 5+) Home	emaker		Homemaker			
פ	filed valued by all Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N	faiden Surname)			
<u>X</u>	ld be Menta narked artic e	၉	Harry Speicher	Celia Mi	ller				
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ailing Address (Street and Number or Rura	· ·				
e ,	and 2 Healt em 2 ther 1			4 Sand Flat Rd., Oal			T. 0		
Baltimore,	age 1 ent of nt: If if		1 Burial 2 Cremation 3 Removal from State cemetery, c	rematory or other place)		20c.Location - City or Lewisburg,			
<u>=</u>	mit. Poartme	1 8	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Wes					
ñ	limp Per			Med. 400 N. Lee St.					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart fallure. List only one cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arre	st,	Approximate Interval Between		
~ 1	hysician/	(6 y	Immediate Cause (Final disease or condition	- E douse I hen	in Peres	16	Onset and Death		
	Medical Examiner		resulting in death)  Due to (or as a consequence of):		1				
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of:	eno Scherosis			yezr_s		
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	BO			(1e2r(		
	execu an an	EX	that initiated events resulting in death) Last Due to (or as a consequence of):	ĺ			4		
2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 heart death.  Within 24 heartal cather death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d						
20	ertifica ding p	/Me	IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome of pregnancy						
XOD	atth or atten for us	Physician/Me	in the past 12 months?	B ☐ Ectopic pregnancy Dother (specify)		23d. Date of de Month	llivery Day Year		
о О	the de by the ached	hysi	9 Unknown 9 Unknown						
Ţ.	s that gned I		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
S S	een si	ted			1 🗆 Ye	☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
necords,	law n hasb e 2 sh	Completed by		<u> </u>	24a. Was an autops	y prior to	ntopsy findings available completion of cause of		
ř	n: The ficate r, pag	-	DE Was again referred to marking		perform 1 \(\sum \) Yes 2		s 2 No		
ם ו	s certil	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpertion 3 FR/Output	26. Place of Death (Check					
5	g Phy er this neral c		27. Manne eath 28a. Date of injury 28b. Time	of 28c. Injury at 2		nce 6 Other (Spec w injury occurred	ify)		
5	endin sath. or: Aft he fur	licat	Natural 5 ☐ Pending (Month, Day, Year) injury	/ work? M 1 ☐ Yes 2 ☐ No					
VISION	or Atter de lirecton by the properties of the pr	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	8f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,		
5	pital c		CO. Cartification District Tall			<u> </u>			
:	P Hos 24 hc Fun leted	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred at	the time, date and	diplace, and due to the	cause(s) and manner stated		
	To the comp		29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont			
			> the	D12333		10/20/	( )		
		- 1	30. Name and address of person who completed cause of death (Item 23a) (Type	•		·			
	CAL		Thomas Johnson, MD 311 N. 4th St., O. 31. Date filed (Month, Day, Year) 32. Signature 32. Signature 33.						
	State Registra		31. Date filed (Month, Day, Year) 32. rgistrar's Signatur (Month) 2011	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Luis Alfredo Jara October 8 8:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 578-68-4623 Director 1 X M 2 🗆 F 77 Yrs July 09,1934 Ecuador Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Virginia Prince William Triangle 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funera 18306 Cabin Road 22172 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iter þ 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 🗷 Yes 2 🗆 No Specify: Ecuadorean Hispanic Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever ည Mateo Jara Rosa De Jara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neyda Jara - Spouse 18306 Cabin Road, Triangle, Virginia 22172 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Pleasant Valley Cem. | 10/20/2011 | Annandale, Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility Everly Community Funeral Care a |6161 Leesburg Pike, Falls Church, Virginia 22044 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part 1. Enter the disease, ox shock, or heart failure. List o Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burnal-yaped signed by the attending physician and d be detached for use as the burial-transit Depression Due to (or as a consequence of): resulting in death) Last Physician/Medical Benign Prostate Hypertrophy IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed' Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 🗶 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D0067092

State Registrar

Box 68760

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year) **OCT 17 2011** 

Wei Han Wang, M.D.,

15245 Shady Grove Road, #130, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ise Type or					e All Copie		_	•		
		For State Registrar				tificate of		id Meritar i i	Reg. I	001	1 3464		
Physicia Medic		<ol> <li>Decedent's Name (First, Middle</li> <li>Leon Kawer</li> </ol>	, Last)					2. Date of D Month		Day Year	3. Time of Death		
Examin		4a. Facility Name (if not institution Montgomery General		ber)		4b. City, Town, o	or Location of D	eath	4	4c. County of Dea			
Funeral Director		5. Social Security Number 579-48-3489	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs.		If Under 1 Year Months Days		Hrs. 8. Date of B		9. Bi	rthplace (State or Foreign ountry Germany		
the Maryland or 28a-f show be notified at	Funeral Director	Usual Residence of Decedent	gomery		ity, Town or Loo			-	109.	Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🔀 No ountry?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 👿 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Never Married 2 ☒ Married  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.			Yes, specify Cub	an, Mexican, Post	? (Specify Yes or No uerto Rican, etc.)	)-	Black, Whi Specify: Wh	merican Indian, /hite, etc. √hite		
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and 2 sho Health an em 27 is ther traus		Joel Kawer - Son	nip ( <i>type, Print)</i>		537 Ke	rsten St.,		Rural Route Numb Sburg, MD 2	0878				
mit. Page 1 and the partment of he portant; If ite injury or of injury or ot		20a. Method of Disposition  1	pecify)	State	David M	sition (Name of natory or other pla emorial Ga . Name and Addre	rdens	Date 10/16/2011	20c.	Falls Chu			
Per Imp any		23a. Part 1 Filter the disease, or			N	ational Fu	neral Hor			, Falls C	hurch, VA 22042		
Physician/ Medical Examiner		she or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Pulk	ch line.	Lem	The mode of dyn	ig, such as can	uiac or respiratory a	arest,		Approximate Interval Between Onset and Death		
To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial traces.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or inique) that initiated events resulting in death) Last	с	or as a consec									
ne death certific / the attending   ched for use as	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1							elivery Day Year			
uires that t n signed b uid be deta	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute  1  Yes 2 No 3											
The law requate has bee page 2 shot	Completed	24a. Was an autopsy performed?								prior to death?	ere autopsy findings available ior to completion of cause of eath?		
ysīcian, s certifii director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	npatient 2	ER/Outpatien	_ Oth	lace of Death (C	Check only one)	idonao	€ □ Other /Spe	2/5/)		
anding Physath.	Certificate: 1	27. Manner of Death  1 Natural 5 Pendin 2 Accident Investig	g 28a. Date of (Mont) gation		28b. Time of injury	28c. Inju	ry at	28d. Describe			-ny)		
rtal or Atterns after de al Directo		3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determi	ned 28e. Place	of Injury - At h		et, factory, office		28f. Location City or To			ral Route Number,		
the Hospi nin 24 hou the Funer	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the be xaminer: On the basi Nurse Practioner: T	s of examination	on and/or invest	gation, in my opini	ion, death occur	red at the time, date	and pla	ce, and due to the	cause(s) and manner state		
2 2 2 2 2		29b. Signature and title of certifier	·	<b>&gt;</b>		29c. Licens <b>D68</b>	658		29d. [	Date signed (Mont	h, Day, Year)		
		30. Name and address of person v	'nd M.D	. 1810	01 Prin	ce Phili	p Dr. O	lney, MD	208	314			
State Registra	-	31. Date filed (Month, Day, Year)  OCT 17 2	011 Bent	gistrar's Signa	par	w.							

DHMH 17 Rev 7/2009

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r	Physicia Medi		1. Decedent's Name (		NE KELLE	7				2. Date of De Month			ear	3. Time of Death
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	yland -f sho ed at	cto		0b. County		10c. City, Town or	Location						10	d. Inside City Limits
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	items er mu	Fun	11. Marital Status	7150117111	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Dece			(Specify Yes or No erto Rican, etc.)	-	14. Race - /	America	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 ☐ Never Married 3 ☐ Widowed 4 [		1 Yes 2 In If Yes, Give Year or Dates.	No	1  Yes			erto Rican, etc.)		Black, V Specify:	White, e	
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	illed wall Hyg	Be	17. Father's Name (Fin	st, Middle, Last)					18. Mother's N	lame (First, Middle	, Maiden	Surname)		
ylar	should be file and Mental F is marked o raumatic eve	To	Charles	Luther	Daugherty	,			Emma	Horner				
Maryland	shou and is m	3	19a. Informant's Nam	e/Relationship (Ty	pe, Print)	19b. M	iling Addres	s (Street a	and Number or I	Rural Route Numb	er, City o	r Town, State	e, Zip Co	ode)
	and 2 Health em 2: ther t		Donald W 20a. Method of Dispos		(Husband				ille Ro	ad - Cri	T			
Baltimore,	Page 1	100	_ '_	Cremation 3	Removal from State		rematory or	ther plac		Date 10/19/2	1	ocation - Cit <b>Crisfi</b>	-	
Bal	permit Depari Impor any in	Į,	21. Signature of Funer Mary B	COLD (	ds late / shaw—Prui	witt	22. Name a	ad Addres	is of Facility B	RADSHAW ( - Crisfic	% SO	NS FUN MD 21	ERA 817	L HOME
	Ph sician/ Medical Examiner	Examiner	23a. Part 1. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death)  Sequentially list cond if any, leading to Immediase. Enter Underlyi Cause (Disease or inji that initiated events	ailure. List only or nal	a. Due to (or as	e.  CONAPI a consequence of:	ART	ERI	y Di'	ac or respiratory a	rrest,		- 1	Approximate Interval Between Onset and Death
09	ria ex	ज्ञ	resulting in death) Las	st	Due to (or as	a consequence of):								
. Box 68760	Attending Physician: The law requires that the death certificate be streeter. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the but	Physician/Medic	IF FEMALE: 23b. Was decedent proint the past 12 mo 1 ☐ Yes 2 ☑ 9 ☐ Unknown	ntbs?	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death	□ Ectopic □ Other (s <sub>i</sub>	pregnanc	у		ĺ	23d. Date o Month		y Day Year
ls, P.O.	uires that the signed by ald be deta	þ	Part II. Other significa	ant conditions co	contributing to death but not resulting in the underlying				, , ,			Did tobacco use contribute to the cause of death?		
of Vital Records,	ician: The law requires certificate has been sig rector, page 2 should b	Completed								24a. Was auto perf	psy ormed?	prior deat	r to com :h?	sy findings available apletion of cause of
alF	ian: T rtifica ctor, p		25. Was case referred examiner?	to medical				26. Pla	ace of Death (C)	1 \(\sum \) Yes neck only one)	2 000	101	Yes 2	2 140
ξ	Physician: this certific ral director,	2	1 🗆 Yes 2 🛂	Vo [+		ient 2 ER/Outpa	ient 3 🗆 D	Othe	r. 4 🗌 Nursing	Home 5 Res	dence	6 Other (S	pecify)	
on of	ending Ph sath. or: After th the funeral	Certificate:	2 Accident	5 Pending Investigation	28a. Date of inju (Month, Da			8c. Injury work 1 🗆		28d. Describe	how inju	ry occurred		
Division	Hospital or Atteno 24 hours after deatl Funeral Director: etely filled in by the		4  Homicide	6 Could not be determined	28e. Place of Inj building, et					28f. Location ( City or To	wn, State	e)		
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check 2 L	Medical Examin	ier: On the basis of a	my knowledge, deat examination and/or inv	estigation, in	my opinio	n, death occurre	d at the time, date	and place	e, and due to	the caus	se(s) and manner stated.
	To To 1		29b. Signature and title	e of certifier	TAR		290	License	number 3678	3		ate signed ( $M$		ay, Year)
_			30. Name and address	of person who co	empleted cause of c	leath (Item 23a) (Type	Print)	ural	ISTRE	et Salis	sbu	mm	0 3	21801
	Stat Registra	100	31. Date filed (Month, L	Day, Year)	32. Registr	ar's Signature	fax	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ October 201°1 KEVIN E. KINARD 23:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospita1 Montgomery Cross Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 27 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 K M 2 F Months Days Hours 577-66-5202 63 Yrs Director Sept 1948 Washington, DC Usual Residence of Decedent show 10a, State 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director notified Maryland Prince George's Hyattsville 28a-f 1 X Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 3609 20784 65th Avenue USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ō þ ve 1968 vates. 1969 1 X Never Married 2 Married 1 K Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Water Treatment Technician Government event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ٥ Claude Kinard Eleanor Beaslev traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette A. Beamer, Sister 1432 Albert Dr., Mitchellville, MD other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Park Crem. 10-24-2011 Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jordan Funeral Service. Inc. 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) LYMPHOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician the burial Physician/Medical certificate be Box 68760 attending p IF FÉMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Dav Pregnant at time of death 2 No by the a g Unknown Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy page certificate 1 ☐ Yes 2 ☐ No Yes 2X No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 4 Nursing Home 5 Residence 6 Other (Specify I Director: After the in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No after death. Accident Investigation M 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hin 24 hours af the Funeral Di npleted filled ir Medical 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 65915 October 12, 2011

Registrar

DHMH 17 Rev 7/2009

State

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Chuanbo

OCT 1 8 2011

Holy Cross Hospital - 1500 Forest Glen, Rd., Silver Spring

MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D..

Zhang.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34645 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (D Day 14 Physician/ Year LEONARDO LA NOIRE 1:46 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore UNIVERSITY OF MARY LAND MEDICAL CENTED BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country Maryland Social Security Number 7. Age (In vrs. last birthday) **Funeral** Dctober 11, 2011 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d, Inside City Limits notified at Funeral Director Beltsville Maryland Prince Georges 1 Tyes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 20705 IISA 12907 Paca Drive and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□No Specify:Peruvian If Yes, Give Year or Dates "natural" Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important, If Item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fernando La Noire Maria Mejia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12907 Paca Drive, Beltsville, MD 20705 Fernando La Noire / Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ostober 17, 2011 cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home, 500 University Blvd., W., Silver 21. Signature of Funeral Service Licenses Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ RESPIRATORY FAILURE Medical resulting in death) Due to (or as a consequence of Examiner AGENESIS Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine dians. HYPOPLASIA PULMONARY Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death s been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law in 24 hours after death.
• Funeral Director: After this certificate has be performed? Yes 2 X N 1 Yes 2 No 25. Was case referred to medical examiner?

1 \( \sum \) Yes 2 \( \sum \) No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ER/Outpatient 3 DOA 1 Nnpatient 2 -27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 19762

BALTIMORE, MD 21201

10/14

SHEELA MOORTHY, MD

17 2011

31. Date filed (Month, Day, Year)

OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEELA MOORTHY, NO. 22 S. GREENE ST,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #65 Res of the 692 had 11 dep 2 the left of Health and Mental Hygiene 1 - State Amend#'s 10a.b.c.e.f.&17.PerFHPQC10-26-194fficate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:40a M Physician/ 2011 Edward Long, Jr. October James Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Montgomery Montgomery Village Sunrise Assisted Living 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) (Month, Day, **Funeral** Days 936 North Carolina Hours Min. 1 XXM 2 XX 75 March **Director** 228**–**46–3748 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County with the Maryland notified at Director Montgorery Village 1 🔀 Yes 2 🗌 No MD Mantagnery Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ò must be 19310 Club House Road 20886 Funeral USA 23a 20024 items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status er than "natural", or ite the Medical Examiner Black, White, etc þ 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. It then 27 is marked other than "hatural", or lart. If then 27 is marked other than "hatural", or jury or other traumatic event, the Medical Examitury or other traumatic event, Specify: Black Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🙀 No 3 Widowed 4 Divorced Year or Dates 1959-64 Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DC Government Engineer 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Edward Sligh Long Lucy James Long 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20817 8611 Rayburn Rd. Bethesda, Md Michelle Long Pittman/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If it any injury or of once. ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Brentwood, Md Fort Lincoln Cemetery 10/14/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service ncensee 20722 3401 Bladensburg Rd Brentwood, Md rances wart I. Enter the diseased or complications that caused shock, or heart failure. Ust only one cause on each line ediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disea Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Ph sician/ Min Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease <u>Years</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Dunita for és a consecuence el Years inding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Chronic Atrial Fibrillation Years Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 ☐ Yes 2X No B B Other: 4 Nursing Home 5 Residence & Other (Specify Asst. Living ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 8c. Injury at Certificate: After work? 1 XNatural 5 Pending n 24 hours after death.

le Funeral Director: After the further th Accident
Suici 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10-11-11 D31391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 604 South Frederick Avenue #413 Gaithersburg, MD 20877 Suhair Abulfarag

DHMH 17 Rev 7/2009

State Registrar 32. Registres Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 2322 N HAROLD LITTLEJOHN JA4183 10 Medical 4a. Facility Name (if not institution, give street and number) PRINCE 4b. City, Town, or Location of Death **Examiner** GEDVORS PRINCE HOSPITAL CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 **X** M 2 □ F 8. Date of Birth **Funeral** 578-56-8506 Min. 70 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Prince GEORGES UPPER MARLBORD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 🗌 Yes 2**X** No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working ife DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Governmen GNVIDEMONTAL SPECIALIST Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) မ LITTLEJOHN VIRGINIA L. HUNTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WASHINGTON, DC 1926 FIBT St NW GREGGER COUSIN LAURALING 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, RIVERDME PK CVEMATON RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee WASH, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a obsequence up burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year 1 Yes 2 L 9 Unknown detached been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has by page 2 s autopsy perform 2 🗌 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) 18 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OMOLULA 0 ADESINA, HD 3001 H054 3001 HOSPIME DRIVE, CHEVERLY, MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MILDRED MILLER 1655 M 0 2011 Medical 4c. County of Death **Examiner** 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel **Annapolis** . Age (In yrs. last birthday, If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 577-34-0526 **Director** 1 M 2 F 86 12/12/1924 New Jersey Usual Residence of Decedent or 28a-f show and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location Director 1 Tes 2 X No Maryland Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 332 Greenridge Drive 20754 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Secretary Lega1 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment.
Important: If item 27 is marked any injury or act. Elwood E. Haines Sarah A. MacDougle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Fitzgerald/ Daughter 332 Greenridge Drive, Dunkirk, Maryland 20754 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery 10/27/11 4 Donation 5 Other (Specify) Cheltenham, MD 21. Signatus fus ral Solvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate Interval Between Immediate Cause (Final Physician. Medical resulting in death) **Examiner** Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MOVIHS CRITICAL and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial CORONARY ARTERY the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မှ Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ within 2 To the I

ROV

State Registrar

only one 29b. Signature

Name and address of perso

My 445

leted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

ENSE HWY ANNAPOLIS MOZINO

Ther 202011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October II, 2011 11:20a M Jeanette M. Moore Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Upper Marlboro 7315 Gambier Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🛛 F Days Hours Min 11-15-1915 Months Salisbury, N.C. Yrs **Director** 95 579-09-4835 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State **Funeral Director** be notified 1 X Yes 2 ☐ No Prince George's Upper Marlboro MD 10g. Citizen of What Country? 9 10e, Street and Number ,s 23a o, c must b United States 7315 Gambier Drive 20772 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: "natural", Completed 3 Midowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) lith and Mental Hygiene. 27 is marked other than r traumatic event, the M College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula Kent Willie Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 7315 Gambier Drive Upper Marlboro M.D. 20772 Patricia M. Harris - Daughter 20a Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery: 10-15-2011 Bladensburg, M.D. 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Linena 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Senile Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth 4 Pregnant a 9 Unknown in the past 12 months? Year Month Day Pregnant at time of death 2 X No g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypertansion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus as e autopsy performed? Yes 2 No certificate ha 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? X Natural 5 Pending 2 🗌 No Investigation

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Accident
Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M Williamson DO 32. Registar's Signature

6 Could not be

determined

H0058032

1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10/12/11

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Suite 600

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4041 Powder Mill Rd. Calverton, MD 20705

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Williams DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AKUNNA MEYEN OLUN 7011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death towar 1 WLUMBIA GFNERM COUNTY HUSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1**X** M 2 □ F KNOWY Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Operating if the 23 or 28a-f sho "Operant: if the 27 and a content than "In the 27 and the content than "In the Page 1." It is a should be a shown in the Maryland of the Taumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 119A Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 ■ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar ပ OKONNA AKak 00 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6209 15 imah 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 30/11 Nigeria 4 ☐ Donation 5 ☐ Other (Specify) Family Compter 21. Signature of Funeral Service Licensee WH Bacon Funeral Home Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician METASTA716 ROSTATE ANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of PLEURAL E FAUSION burial-transit ILATERA and Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown Atter this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending Investigation 1 🗌 Yes 2 🗌 No completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0059649 OCT 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HICKORY RIDGE RD #215 COCUMBIA, MD 21644 10801

Registrar

State

KECHUKWU

31. Date filed (Mont)

mo

Kegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 8:30 P.M MARJORIE HELEN SCHMITZ Medical Facility Name (if not institution, give street and number) ocation of Death **Examiner** nty of Death If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** WI -1 ☐ M 2**X** F 93 Months Davs Hours Min 1 1 1 9 1 9 1 7 579-28-7523 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director ANNE ARUNDEL LOTHIAN MD. 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? 31 PATUXENT MOBILE ESTATES 20711 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married 72 hours after and 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify.WHITE "natural" Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within College (1-4 or 5+) SALES ASSOCIATE BAKERY 11th is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 0 JOHN McBAIN EDITH WALTERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL NORWOOD-GRAND DAUGHTER 105 NORTH WILTSHIRE CT. LA PLATA, MD. 20646 permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TR cemetery, crematory or other place) TRINITY 10-29-11 MEM.GARDENS WALDORF, MD. Name and Address of Facility
AYMOND FUNERAL SE
A PLATA, MARYLAND M00479 21. Signature of Funeral Service Licensee SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year After this certificate has been signed by the a funeral director, page 2 should be detached death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 WN 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 popatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident
Suicide Investigation after death Director: / completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical 29a. Certifier the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated by Manner stated at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical E within 2 To the only one ifvin 29b. Signature and title 29d. Date signed (Month, Day, Year,

Registrar

State

30. Name and address

3

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 14, 2011 Sharp 12:30 a M Heath Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bedford Court Nursing Home Silver Spring 9. Birthplace (State or Foreign Country) MI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye April 24, Social Security Number . Age (In yrs. last birthday, **Funeral** Days 1 🐹 M 2 🗆 F 95 Director 369-14-1459 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f showere, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Silver Spring 1 Yes 2 X No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 20906 3701 International Drive, Apt. 748 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. White 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 ☒ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ Edna Kathern Heath Burk Hart Sharp traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 14904 Peach Orchard Road, Silver Spring, MD 20905 Barbara L. Laudet/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Oct. 14, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, VA 21. Signature of Funeral Service Licensee F2. Name and Address of Farily ins Funeral Home 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or imjury that initiated events resulting in death) Last attending physician and for use as the buriactia Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Collyin 24 hours after death.

Let the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 XNo မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\boxtimes$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) October 14, 2011

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who

Nakul Goyal,

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

#211

3801 International Drive, Silver Spring, MD 20906

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Naomi Hartung Snook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fairhaven Retirement Community Svkesville Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🗓 F Country) 215-18-6640 Director 101 Usual Residence of Decedent and Mortal Hygiene. and Mortal Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Sykesville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 Third Ave. 21784 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bookkeeper heavy equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernie Elizabeth Arnold Henry Hartung 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Bristol Terrace, The Villages, FL 32162 Jeanne Whitmer (Niece) other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otf cemetery, crematory or other place) 1 Burial 25 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory10/14/11Smithsburg, <sup>22</sup>Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of) and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant 9 Unknown 1 Yes 2 9 Unknown is been signed by it should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cognitive impairment Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) director, Be Other: 1 ☐ Yes 2 📉 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Registrar

State

31. Date filed (Mont

egistrar's Signature

Eldershurg

Kuad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11<sup>Day</sup>2011<sup>Year</sup> Month 7:45A M Physician/ Phyllis Anne Sullivan Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Meritus Medical Center Hagerstown 9. Birthplace (State or Foreign Countre) C 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Hours Min 1 🗆 M 2 🚾 F (Mgn#n2Pay, Year)923 88 577-20-6181 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 XNo MD Smithsburg Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21783 USA 13903 Wolfsville Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Was Decedent 2.5.
Armed Forces?
1 Yes 2 No Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important, if item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany once. Elementary/Seconday (0-12) College (1-4 or 5+) multilith operator analytical services Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorelle Bettis ပ Reuben L. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13903 Wolfsville Rd., Smithsburg, MD 21783 Alex Sullivan (Husband) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 K Burjal 2 Cremation 3 Removal from State Harmony Cemetery 10/15/2011 Myersville, Ponation 5 - Other (Specify) ture of Fune of Ser 22. Name and Address of Facility
Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 ligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of cause on each line. . Part 1. Enter the disease, or co shock, in heart failure. List only Approximate Interval Between Onset and Death Immo iate /ause (Final disease ondition Physician/ he is tesder 1 Stee hours Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading cause. Enter Underlying iner Atmil Abrille -transit years. Exam Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 1 ☐ Yes 2 2 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

this certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director,

Be

Certificate: To

Medical

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25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1  lnpatient 2	☐ ER/Outpatient 3 ☐ [	Other: 4 \( \sum \) Nursing H	ome 5 Residence 6 C	Other (Specify)					
27. Manner of Death  1       Natural 5 □ Pending 2 □ Accident □ Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occ	urred					
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			ry, office	28f. Location (Street and Nur City or Town, State)	nber or Rural Route Number,					
(Check 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examinations rse Practioner: To the best of r	on and/or investigation, in	n my opinion, death occurred	at the time, date and place, and	due to the cause(s) and manner stated					

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Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kern E. Hohlms Box 20,

1 Holl no

Day, Year)

29b. Signature and title of certifier

31. Date filed (Month,

300 S. Chu 32 Registrar's Signatur ence

Md 21769 L St.

29c. License numbe

D43780

29d. Date signed (Month, Day, Year)

10/14/11

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 7:00 A October 0 11 Thomas Edward Smith 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Mt. Airy Howard 685 Long Corner Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 04/02/1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number Days Hours 1**X** M 2□ F Months TN 86 415-22-0500 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Howard Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21771 685 Long Corner Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 1 X Yes 2 ☐. If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 □Yes 2 No Specify Specify: 3 Widowed 4 Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) teacher Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

20b. Place of Disposition (Name of cemetery, crematory or other place,

Stauffer Crematory

Ethel Sloan

685 Long Corner Road, Mt. Airy, MD 21771

#111, Olney, MD 20832

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

23d, Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ►No

Month

mouths

Year

10/14/2011 | Frederick, MD

22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

> Physician/Medical Examiner 至 Completed

> > Medical

For State Registrar

10a. State

MD

Willie Ray Smith

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

Barbara Flynn Smith/wife

1 ☐ Burial 2 A Cremation 3 ☐ Removal from State

Director

Funeral

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Completed

Be

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**Physician** 

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I's Madical Examiner must be notified at

of Health and Mental Hygiene. Item 27 is marked other than

other t

Department of H Important: If ite any injury or ot once.

/Medical

attending physician and for use as the burial-tran the s been signed by the should be detached certificate has birector, page 2 s funeral director, Be Certification: To this After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760,

23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): relod Sequentially list conditions, any, could be transcribed cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MS Unknown 24a. Was an autopsy perform performed? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D39190 10/12/2011

3418 Olanwood Ct.,

32. registrar s Signature

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Allen Reilly,

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State o	f Marylan	d / Depa	artment of H	lealth a	and N	lental Hyg	iene		
			1 - State Registrar				Cei	rtificate of	Death		F	eg. No.	2011	34656
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	To the Nostrial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifier (Check only one) 2 Me	rtifying Physi dical Examin	cian: To the er: On the ba and mann	asis of examinal	wledge, death ion and/or inv	occurred at the tirestigation, in my o	ne, date an pinion, deat	d place, th occurr	and due to the d ed at the time, d	ause(s) a late and p	and manner a lace, and due	is stated. e to the cause(s)
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State Registrar

31. Date filed (Month, Day, Year)

OCT 17 2011

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# permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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Funeral	11. Marital Status	nam st.	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of Hispan Yes, specify Cuban, Me	ic Origin? (Spec	ify Yes or No-		14. Race - A		
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		ne Vaugha				. Main St.						
	20a, Method of Dis	sposition	☐ Removal from State	20b. Place	of Dispo	sition (Name of natory or other place)		072011		ocation - Cit	y or Tov	vn, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Trem 3 per med cert G920 10/31/11 dk
State of Maryland Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Washington 8 10:30 A M 6 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MD Ft Washington Reba Center Ft Washington, PG If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 - 1 1 - 1 9 1 9 Birthplace (State or Foreign Country)
 SC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F 92 Yrs Director 248-30-8642 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itams 23a or 28a-f show the Medical Exurities must be notified at X Yes 2 No MD PG Ft Washington, MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2006 Wolf Road 20744 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status X Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No spo Bylack Specify 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Self Home Maker 5th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Luther Washington Sr. Luella Frazier Washington 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar trat once. Juanita Lloyd Stanton 62 W 62nd St #3D, New York NY 20023

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The option of Date Polace Aug 15,

The option of Dat 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)
Ft. Lincoln 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 2011 22. Name and Address of Facility Dunn & Sons, Funeral Service 21. Signature of Funeral Service Licensee 5635 Eads Street NE, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of fyrig, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Placerof Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. May er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide 24 hours a Funarai [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) ٥ 29c. License number 08,14,201, 30. Name and address of person wno completed cause of death (Item 23a) (Type, Print)

7700, Old Svanch Fue, Clin

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nathaniel Walker Medical Oct 17,2011 00:55 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ft Washington Ft Washington Hospital Prince Georges **Funeral** Social Security Numb . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🙀 F Months Hours Director Sept 4, 1925 86 252-28-8610 Barnwell SC Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince Georges Forest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5704 Blackhawk Drive 20744 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Twelfth **Painter** Private None 1 and 2 should be filed with Hagington Mental Hygington 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nathaniel Walker Sr Mary Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5704 Blackhawk Drive, Forest Heights MD 20744 Essie M. Walker/Wife If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State portant: If y injury or cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Oct 26, 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 2011 permit.
De artr
Importa
any inji . Signature of Funeral Serv Licensee Donald R. Gray 22. Name and Address of Facility Robert G Mason Funeral Home Inc 1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1 Enter the disease, or comp shoot, of heart failure. List only or Immediate Cause (Final ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death ronic Obstructive Pulmonan Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine day, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of performed' death? 1 Yes 2X No Yes 2X No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 5 Pending (Month, Day, Year) Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tit 29d. Date signed (Month, Day, Year) 10/18 D0053117 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 11711 Livingston Road, Ft Washington MD Patrick Daly MD 20744 31. Date filed (Month, Day, Year) 32. Reg State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18. 2011 10:20 AM October Annabel Rose Stein Wenk Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Feb. 24, 1926 Washington, DC Director 537-22-5803 85 1 □ M 2 **X** F 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. Count Examiner must be notified at Director 1 X Yes 2 No Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10 10e. Street and Number 23a Funeral United States 21702 1900 Rosemont Avenue items death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Personnel Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental h ပ္ Geneva Mary Denker John Paul Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 28519 235th Ct., SE, Maple Valley, WA 98038 Barry Stein / Nephew other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 20. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 2011 Smithsburg, Maryland 21. Signature of Funeral Service Licenses Keenevandades Bastord PA Funeral Home, MO1473 106 E. Church Street, Frederick, MD s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death Unknown þ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 has autopsy performe 1 Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 5 Pending XNatural Accident
Suicide Investigation Director: A 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 18, 2011 D60417 ~LD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah, M.D. 65C Thomas Johnson Drive, Frederick, Maryland 21702

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First Middle Last) 2. Date of Death Physician/ THOMAS JOSEPH 2011 October 11:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Angel Gardens Assisted Living Silver Spring Montgomery If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours (Month, Day, Year) 578-20-8113 88 **Director** 1 X M 2 D F Dec. 11 1922 West Virginia Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland 1 Yes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11411 Ashley Drive 20852 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1942—
If Yes, Give 104.4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: Specify: White "natural", 3 Widowed 4 Divorced 1944 Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Computer Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Unknown Gertrude Bover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella D. Ward / Wife 11411 Ashley Drive, Rockville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 10/14/11 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Eacility Muriel H. Barber Funeral Home Ro Box 5038, Laytonsville. 20882 0. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dysphagia 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Debility certificate has autopsy performed?

Yes 2 No 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? **Assisted** 1 ☐ Yes 2 ☑ No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Optifying Narse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of der 29c. License number 29d. Date signed (Month, Day, Year) 38457 October 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SX 3801 International Dr., #211, Silver Spring, MD 20906 Nakul Goyal M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 2011 STEWART WRENN 9 1:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Months Days Min. (Month, Day 1 M 2 X F Hours <sup>Year</sup> 1925 North Carolina **Director** Dec. 241-32-8397 85 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 K Yes 2 No Frederick Frederick Maryland 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 100 Burgess Hill Way Apt. 213 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. "natural", or 1 ☐ Yes 2 🄀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဂ Luther D. Stewart Macke Barefoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 10994 Horseshoe Drive, Frederick, Maryland 21701 Stuart Wrenn item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place. 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park Smithfield, NC 21. Signature of Ineral Service License Stauffer Funeral Homes 1621 Opossumtown Pike, Prederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiovascular W. SIGIL 12000 1ers disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and trar that initiated events resulting in death) Last Due to (or as a consequence of) burial-t physician the buria Physician/Medical Division of Vital Records, P.O. Box 68760 the attending plants IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Month Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Μ 1 🗌 Yes 2 🗀 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

Gene F. 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Year)

Ashe MD 10200 Coppermine Road, Woodsboro, Maryland 21798

29c. License number

D31058

29d. Date signed (Month, Day, Year)

10-10-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alfred Young 13, October 0 2011 4:20 aM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 12916 Allerton Lane Silver Spring 9. Birthplace (State or Foreign Country) IN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months 1 X M 2 D F Hours Sept. Day, Director 310-14-3441 91 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Examiner must be notified at any injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20904 USA 12916 Allerton Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 2 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed WWII Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Phillip Young Marie Skully 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12916 Allerton Lane, Silver Spring, MD 20904 Mary Ann Young/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 14, <sup>Oct</sup> 2011 Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Signature of Funeral Service Licenses Inc. Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Congestive Heart Failure e attending physician and do for use as the burial-trans Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Peripheral Vascular Disease, Chronic Kidney Disease 1 M Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 0023888 30. Name and address of person who completed cause Juan Arguinzoni, MD (Item 23a) (Type, Print) Wisconsin Avenue, Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year) 0CT 17 2011

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:30 PM 2. Date of Death Physician/ Month October 31, Year 201 Irene W. Avery 1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19 Sylvan Park Ct. Nottingham Baltimore **Funeral** 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 86 578-38-6538 1 ☐ M 2 🚉 Months Days Hours Min North, 13 Year 1924 England Director Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d, Inside City Limits Examiner must be notified 28a-f MD Baltimore Nottingham 1 Ves 2 Min ō 10e. Street and Number 10f. Zip Code 10q, Citizen of What Country? 23a Funeral 19 Sylvan Park Ct. 21236 United States "natural", or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: 3 🗌 Widowed 4 🗆 Divorced If Yes Give White Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Gertrude Pitchers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted Avery /Husband 19 Sylvan Park Ct. Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₹6v 02 cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Kinson disease or condition equs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Tunknown page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ٩ Hospital 2 (3No Other: within 24 hours after deau..

To the Funeral Director: After this in the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Serting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, in my opinion.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, DOO 6 1199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST Swite 4105 Towson MD 21204 6V 701 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat 2:50P Physician/ OCTOBER 20°11 John thomas Antlitz Medical 4a. Facility Name (if not institution, give street and number)
SAINT JOSEPH MEDICAL 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER BALTIMORE TOWSON 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days Hours 216-14-4366 1 M 2 D F **Director** Maryland 8-11-1923 88 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County must be notified at Director 1 X Yes 2 No Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 4502 Bayonne Avenue 21206 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces Black, White, etc. "natural", or 1 Never Married 2 Married 1 X Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Policeman Baltimore City Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H is marked of Elizabeth Derwart George Antlitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sh nt of Health a 3 Bramleigh Garth Lutherville, Md. 21093 DTR. Patricia Rolfes 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 ament of I 1 K Burial 2 Cremation 3 Removal from State Ь Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus 10-29-2011 Dundalk, Md. 21. Sign vere of Fundral Service Licenses 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc 6415 Belair Road Balto. Md. 21206 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Ph<sub>y</sub>sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CONGESTIVE HEART FAILURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) FAILURE ACUTE RENAL and that initiated events Due to (or as a consequence of) resulting in death) Last burialsigned by the attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Tes Yes 2 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ည 1 Xnpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury XNatural 5 Pending Investigation Accident filled in by the Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 25, 2011

State

31. Date filed (Month

150

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MD 21204

D67248

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			for State Registrar	Otato of	iviai yid		rtificate of			nornar r ry	Reg. No	$\cap$ I I	34666	
	Dhysisi	/	1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath	<u> </u>	3. Time of Death	
	Physicia Medi		Mildred Ward		October				201 <sup>Year</sup>	8:00 A M				
	Exami	ner	Rockville Nursi	Rockville Nursing Home					4b. City, Town, or Location of Death Rockville				ry	
	Funeral Director		5. Social Security Number 212–05–0563	i. Sex 7. 1 □ M 2 <b>X</b> F	Age (In yrs. 100	last birthday)	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birthplace (State o Country)		
		1	Usual Residence of Decedent	I L W Z AL F	100	Yrs.			1	December	19, 191	Mar	yland	
	ryland -f sho ied at	ctor	10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside City Limits	
	he Ma or 28a notif	Dire	Maryland Montg  10e. Street and Number	omery			Rockvi	lle_		····	10° Citizon	of What Cou	1 🔀 Yes 2 🗌 No	
	with t	Funeral Director	303 Adclare Roa	ıd				850			United			
	death items		11. Marital Status	12. Was Decede		.S. 13.	Was Decedent of H	Hispanic C	origin? (Spe	cify Yes or No-	14.	Race - Americ	can Indian,	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Never Married 2 Married 3 😾 Widowed 4 Divorced	d 1 Yes 2 If Yes, Give Year or Date	X No		1 ☐ Yes 2 🕱 No	Specia		Thour, etc.,		Black, White, cify: <b>Whit</b>		
15	72 ho n "na Aedic	nple	15. Decedent' (Specify only highest	grade completed)		(Give	dent's Usual Occup kind of work done OO NOT use retired	durina mo	ost of worki	ng	16b. Kind o	of Business/In	dustry	
212	within giene. er tha , the l	Co	Elementary/Secondary (0-12)	College (1-4	or 5+)	I —	visor	,			   Phon	e Comp	anv	
pu	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Las	st)		<u> </u>		18. Mot	ther's Name	e (First, Middle,				
ryla	uld be d Men marke natic	-	Edward G. Ward			1			attie					
Ma	12 sho Ilth an <b>27 is</b> r	3	19a. Informant's Name/Relationship  Steven D. Ward/0		) OT		ng Address (Street							
re,	1 and of Hea item		20a. Method of Disposition	•	20b.	Place of Dispo	1 Wetherf	- 1		Potor Date inber 4,		aryLand on - City or To		
im	Page ment a ant: If ury or		1 😾 Burial 2 🗋 Cremation 3 4 🗆 Donation 5 🗆 Other (Spe	☐ Removal from St ecify)	ate Fe	rest 0. rest 0. emeter	matory or other pla ak Y	ce)	Nover 201	- 1	Gaith	ersburg	g, Maryland	
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	Ph <sub>sician/</sub>		Immediate Cause (Final	y one cause on each	line.				is cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
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9289	eath certificate b attending physi I for use as the l	J/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome	me of pregna	ancy								
Box	Attending Physician: The law requires that the death certificate ar death.  **redeath.**  ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live Bir 4 ☐ Pregnar 9 ☐ Unknov	nt at time of		Ectopic pregnand Other (specify)	СУ				Date of delive Month	Day Year	
P.O.	s that i	by P	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the ι	ınderlying cause gi	ven in Par	t I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?	
rds,	requires been sig should b	ted								1 🗆 1	Yes 2 N	o 3 🗆 Prol	oably 4 🛭 Unknown	
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Divi	e Hospital or Attend 124 hours after death e Funeral Director: A letely filled in by the f		4 ☐ Homicide determine	building,	etc. (Specif)	<i>'</i> )				City or Tow	n, State)			
	To the Hospital or Atteno within 24 hours after death To the Funeral Director; completely filled in by the	Medical	only one) 3 Certifying No	nysician: To the best miner: On the basis o urse Practitioner: To	of examinatio	n and/or invest	tigation in my opinio	on death o	occurred at a	the time date a	nd place and	due to the car	ise(s) and manner stated	
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	,		30. Name and address of person who		<del>- '</del>	23a) (Type 5		4733	U		Octobe	r 31,	2011	
5	√		Thomas V. Joseph	, MD 50	West 1	Edmonst	one Driv	e, #.	207,	Rockvi1	le, Ma	ryland	20852	
	Stat	е	31. Date filed (Month, Day, Year)	32. Regis	strar's Sigra	ture bar	Kal				-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 29 Physician/ OCTOBER 2011 ALICE BANCELLS 1:05 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) May 21, 1925 Min. 1 □ M 2 🔀 F 266-32-9569 86 **Director** Key West,FI Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Parktcn 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code **21120** 10g. Citizen of What Country? Funeral 21300 Lentz Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Completed 3 XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homenaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blas Rogelio Ramirez Maria Ignacia Pons 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21300 Lentz Road Parkton, Maryland 21120 Carol Bancells (daughter inlaw 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hew failure. List only one cause on each line.

Immediate Cause Fir al disease or condition resulting in death)

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility

20. Name and Address of Facility

21. Name and Address of Facility

22. Name and Address of Facility

23. Name and Address of Facility

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26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility

20. Name and cemetery, crematory or other place)
Bel Air Memorial Cardens Forest Hill, Maryland Name and Address of Facility Evans Funeral Chapel & Cremation Services Mankton 16924 York Road Mankton, Maryland 21111 Approximate Interval Between Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Acriestenosis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No ☐ Yes 2 NIC To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 \( \text{Yes} 5 Pending Division 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D32297 O-T-b-- 9), 2011 Jans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD 21014 BEL AIR, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature State

DHMH 17 Rev 7/2009

Registrar

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er	4a. Facility Name (if no: <b>Gilchrist</b>			ımber)			4b. City, Town,	or Location				4c. Count			
	5. Social Security Num	_	Sex	7. Age	(In yrs. last bi		If Under 1 Year	_If Und	er 24 Hrs.	8. Date of B	irth			thplace (State	
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	Mr.Christo	opher H	. Bread	y (So	on)	34 Ce	edar Ave	· !	Towso	n, Mary	land	1 2	21286	5	
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State Registrar ARATHT KULDR 31. Date filed (Month, Day, Year) NOV 0 1 2011

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Octobe! Physician/ 5:51PM Darlene Brodie 20/1 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George's Doctor's Community Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Hours Feb 15, Year 956 Pennsylvania 198-44-6720 55 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Adelphi 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Completed by Funeral 2017 Quebec Street 20783 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after cament of Health and Mental Hyglenca.

The state of the st 1 Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Otis C. Brodie Sr. Joan Perry 19a. Informant's Name/Relationship (Type, Print)

Joan Brodie (Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Mother) 6445 N. 15th Street, Philadelphia, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3X Removal from State Northwood Cemetery 11/3/2011 Philadelphia, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilityLatimore Funeral Services, PA 2818 E. Baltimore STreet, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Adult Respiratory Distress Syndrome disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions. Disk to for as a consequence of if any, leading to immedicause. Enter Underlying Hypoxerimia Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Severe mixed acidosis To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the built completed filled in by the funeral director, page 2 should be detached for use as the built. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Dav 5 Other (specify) Pregnant at time of death 1 L Yes 2 2 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2021 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D00052557 Abebe, MD 10/27 Amare 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMARE ABERT 8118 GOOD Luck Rd, Lanham, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

2. Date of Death

3. Time of Death

Amend #19a, State of Marriand Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death Physician/ Carolyn Elise Brown 0ctbber 28, 2011 6:00 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Country 219-10-8980 **Director** 1 🗆 M 2 🕱 F 85 March 16, 1926 Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Baltimore Towson 1 Yes 2 X No ò 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Glen Ellen Court U.S.A. 21286 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify. "natural" Completed 3 X Widowed 4 Divorced Specify. White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own home Be Department of Health and Mental Himportant: If item 27 is marked oth any injury or other traumastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Nicholas Miller Mary Elise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra B. Howard-daughter 5 Glen Ellen Ct., Towson, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 11/2/11 Timonium, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd <u>Towson.</u> MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) g physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as attending for use as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 9 Unknown 2 100 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has performed Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural n 24 hours aner he Funeral Director: After he funeral filled in by the fur 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying, Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titl of certifi -007/040 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

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gistrar's Signature

KUMAR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2011 Beulah G. Brucker 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1500 Providence Road Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min Jan 8 Year) 921 214-16-5758 90 Wyoming Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mirst he motified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Marvland 1 Yes 2 X No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21286 U.S.A. 1500 Providence Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3x Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Black & Decker Draftsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hoffman Julian S. Gent Thelma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elva LeNora Tavlor / Sister 3116 N. Rolling Road Baltimore, Maryland 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/1/2011 4 Donation 5 Other (Specify) HilltopServiceCorp Towson, Maryland . Signature of Fu 22. Name and Address of FacilityRuck Towson Funeral Home, 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Weeks Immediate Cause (Final Failure to thrive Physician/ disease or condition \* Medical resulting in death) Due to (or as a consequence of) **Examiner** Congestive heart failure Years Sequentially list conditions, Physician/Medical Examiner Tue to for as a densequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2X No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signatur 29d. Date signed (Month, Day, Year) 0032453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hunt Valley Mark Lamos State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHOBER Medical 4a. Facility Name (if not institution, give street and number, **Examiner** City, Town, or Location of Death 4c. County of Death timore NIA **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Months Hours 6 **Director** Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) ver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 nestine permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Servide License 21229 22. Name and Address of Facilit 23a. Part 1 Fyfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectonic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has a second of the continuation of the continua performed' Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Anatural 5 Pending 1 🗌 Yes Accident Investigation 2 🗌 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOAII3 A. HASHMI MD, 821 N. EUTTHW ST SINTESOF, BALCIMORE MD 21201

D 31464

(0/28/11

MD

32. Registrar's Signature

Examiner or Attending Physician: The law requires that the death certificate be executed nding physician Box 68760 P.O. Records, of Vital To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Division

completed

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

or 28a-f show

ed other than "natural", or items 23a or 28a-f sho event, the M. Ucal Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the M. iteal Examiner mu

Physician/

Medical

Baltimore, Maryland 21215-0036

State Registrar

dical Exami	cause. Enter Underlying Cause (Disease or iirijury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown	23d. Date of delivery Month Day Year
ρ	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown
Completed			24a. Was an autopsy performed?  1 \( \sum \) Yes 2 \( \sum \) No \( \sum \) No \( \sum \)
Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	aly one)
2	1 ☐ Yes 2 🔀 No	Hospital:  1	5 Residence 6 Other (Specify)
	27. Manner of Death  1 🛣 Natural 5 🗌 Pending 2 🔲 Accident Investigatio	(Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No	I. Describe how injury occurred
edical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)
ledic	(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and d iner: On the basis of examination and/or investigation, in my opinion, death occurred at the production.	time, date and place, and due to the cause(s) and manner stated

D46529

PARKWAY GREEOBELT MARYLAND

29d. Date signed (Month, Day, Year) DCTOBER 23, 2011

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7325A HAMENER

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 22 20 Î Î **JAMES** REGINALD 8:30A Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Fort Washington Hospital Fort Washington Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1**X** M 2 □ F Months Hours **Director** 235-60-9399 Nov. Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 K No Prince Georges Fort Washington 10e. Street and Number ō 10g. Citizen of What Country? Funeral 23a 8711 Jolly Lane 20744 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No 3 Widowed 4 Divorced Completed Year or Dates. 1957-1959 **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed wm. ∽tal Hygiene. ∽er than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Painter Self-Employed marked other Be 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Mason Dorothy Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Sandra Bibb/Wife 8711 Jolly Lane Ft. Washington, MD 20744 permit. Page 1 and 5 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Heritage Cemetery 11/01/2011 Waldorf, MD 21. Signature of Funeral Service Licenses Marshadd Marchity Funeral Home of Maryland iclarias 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Directo for as a consequence on NSUFFICIENCY Exami or Attending Physician; The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the inding pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ţ Month Day Year Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X this certificate 1 ☐ Yes 2 X No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 2 XNo 욘 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dympatient 2 🗆 funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1X Natural 5 Pending 1 Tes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti Day, Year) 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hien Trinh Nguyen 6104 Old Branch Avenue Temple Hills, MD 20748 31. Date filed (Month State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34675 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RRYANT Physician/ KENNETH 8.29AM Year 2011 occuser Medical Examiner 4c. County of Death Baltimore Northwest Randallstown Hospital 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Funeral Months Director 1.**X**M 2 □ F 71 Yrs 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director or 28a-f MD Baltimore 1 Xyes 2 No 10g. Citizen of What Country? Pennsylvania Avenue, 21201 USA items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, uith and Mental Hygiene.
27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Washington Willie Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Brunnt, Jr. (Son) 4 Shastacircle Owings Mills Department of Health Important: If item 27 any injury or other the once, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition J<sub>Date</sub> 1 Burial 2 Cremation 3 Removal from State 03/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Ad res of Facility VUUMN C. GREENE FUNEVALS-11CLS Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, each as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) tor: After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the buria Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ENDSTAGE REWAL DISEASE DERIDHERAL VARIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an THROM BOCYTUP GNUA DISCASE performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗌 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No 1 Yes ျှ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 28 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HUSPISM CENTER RANGARAJAN f RAMAGWANY 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34676 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rodger Dale Bucy October 1 2011 ll:23 a <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3425 Plum Tree Drive Apt. K Ellicott City Howard 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 235-82-5996 1 ★2 M 2 □ F 61 08/29/1950 Usual Residence of Decede W\7 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ms 23a or must be r Funeral 3425 Plum Tree Drive 21042 Apt. K United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 4 Computer Analyst Johns Hopkins APL of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Eugene Bucy Mavdell Luter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Cheryl Ann MeGie - sister 5570 Daughtery Road Long Beach, Mississippi 39560 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 1 🗌 Burial 2 🗌 Cremation 3 🛂 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 11/1/2011 Bethel Cemetery Buchanan, TN 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signal up of Funeral Service License 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a consequence of): **Examiner** 54ears Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Finknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 🗆 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Aesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending (Month, Day, Year) 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

only one) 29b. Signature and title of certifier

anes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Warren M. Ross, M.D.

Cas

4801 Dorsey Hall Suite 201 Ellicott City, MD Orive. 31. Date filed (Month, Day, Year)

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1782

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ Ellen Jeannine Blackowicz 201 9:13P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7903 Lowtide Court Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Davs Hours Director 220.38.9561 1 M 2XXF May 18, 1942 69 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ?? 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7903 Lowtide Ct. 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. Yes 2XX No If Yes, Give Completed by 1 Never Married 2xx Married 1 Yes 2 XXNo Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Reid Dorothy Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Blackowicz Husband 7903 Lowtide Ct., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State Crownsville Vet Cemetery Oct 31, 2011 Crownsville, MD 4 Donation 5 Other (Specify) 21. Sig ure of Funeral Service 22. Name and Address of Facility Fink Funeral Home, P.A. Kally Gregory M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ?4 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2- No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 D No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ᇛ 1 🗌 Yes 2/1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ≯-KNatural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific pleted cause of death (Item 23a) (Type, Print) 550 31. Date filed (Month, Day, Year) State NOV O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ORACE Medical 4a. Eacility Name (if not institution, give street and number) **Examiner** Center 4b. City, Town, or Lecation of Death 4c. County of Death AShING TON / red CDI GLEN If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1**XX**M 2 □ F Days Min (Month, Day, Year) Aug 15, 1939 251-60-1589 Director SC Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-1 XX Yes 2 No SC Camden Kershaw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a USA 2215 Pickett St. 29020 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 XXMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxx No Specify: "natural", Specify: Black 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Lab Technician Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve ٩ Sam Belton Minnie Drakeford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 Pickett St., Camden, SC 29020 Frances J. Belton Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place)
 Belton Cemetery 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Camden, SC 4 Donation 5 Other (Specify) Nov 4, 2011 urd of Funeral Service License 22. Name and Address of Facility
Fink Funeral Home, P.A. 21. Signa Gregory Fink M01148 426 Crain Hwy. S., Glen Burnie, MD 21061 23a. Part 1. Enter the disea complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ A THERO SCLELOTIC CAMIONASCULAL disease or condition resulting in death) YEAS. Medical Due to (or as a consequence of) Examiner HYPOGLYCEM IA 30-45 Min Sequentially list conditions. cause. Enter Underlying Exami CARDIO PULMBNARY Cause (Disease or linjury MINUTES that initiated events resulting in death) Last Due to (or as a consequence of nding physician Physician/Medical Box 68760 as the yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deal Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 1 ☐ Yes 2 ☐ No the Funeral Director: After this certific npleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 KYes 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 XNatural 5 Pending injury work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a
To the Funeral C 1 Kcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

Records,

Division of Vital

HOSPITAL DAINE,

301

GLEN BURNE MS

21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAND

ANIEL 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 34679 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:36 ctober 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death he Johns Himore Hopkins 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Country Director 042-28-2942 1 XX/ 2 - F Dec 9, 1935 76 CT Usual Residence of De 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified MD Wicomico 1xx Yes 2 No Salisbury 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a USA 21804 3110 Mount Herman Rd items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ō þ 1 Never Married 2 XX Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene. than Elementary/Secondary (0-12) College (1-4 or 5+) Pharmaceutical Microbiolaist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary McCormack Vincent James Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 12196 54 Avon Court, West Sand Lake, NY Chris Boyle 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 ☐ Burial 2 XXCremation 3 ☐ Removal from State cemetery, crematory or other place Department of Important: If any injury or once. ALbany Rural Crematory 4 Donation 5 Other (Specify) Nov 5, 2011 Menands, NY . Signature of Funeral Service 22. Name and Address of Facility Fink Funeral Home, P.A. Gregory Fink 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical **Examiner** ecunonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for de a consequence of: use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day 2 No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes 2 W 1 Yes the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accider ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 26, 201T Leslie Barnes 11:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number 6. Sex 1 **X** M 2  $\square$  F If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours 240-01-0964 North Carolina Director 94 November 8 1916 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland 1 Tes 2 X No Montgomery Germantown 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? pe 23a must 20111 Laurel Hill Way 20874 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? 0. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced WWII Specify: Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be file Health and Mental H tem 27 is marked of ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Dawn Hall / Great Niece 20111 Laurel Hill Way, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 3 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Ivy Lawn Cemetery Ventura, California 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. ette M01305 Mr 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. For er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death signed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? autopsy performed? ☐ Yes 2 No this certificate 2 No 1 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation Could not be Suicide 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Certified nurse Practitioner 139631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LXIV CRNP 301 Russell Avenue, Gaithersburg, Maryland 20877 Elizabeth A. Kim, 31. Date filed (Month, Day, Year) Registrar's Signati State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 34681 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 27, 2011 9:55 Lewis Thomas Bruffy, Jr. Рм Medical 4a. Facility Name (if not institution, give street and number) 27.2011 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Dec. 24 Hrs. | 7 Per 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 19 24 | 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country irginia 1 X M 2 D F 86 223-28-2956 Director Usual Residence of Decedent OCTOBER show 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland notified at Director 28a-f Rockville 1 X Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or other traumatic event, the Medical Examiner must be Funeral 20850 United States 9529-1 Veirs Drive , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married X Yes 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 🗌 Widowed 4 🗍 Divorced WW II Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Utility Company Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Carrie Lee Richeson Lewis Thomas Bruffy, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9529-1 Veirs Drive, Rockville, Maryland 20850 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marjorie L. Bruffy/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Montgomery crematory or other place) Date October 30, 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 2011 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final septic Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director, After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month 4 Pregnant a signed by the a 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by difficile cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Thunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No upleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 D No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

comple 29c. License number 000 68080 10/28/11 1941 ause or death (Item 23a) (Type, Print)
agol Medical Center Drive Pockville, Maryland 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jalli, MD 32. Registrar's a gnatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:19 2011  $\mathbf{A}^{\mathsf{M}}$ October 26. Dorothy B. Blanchard Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** April 9 Days Hours 1 🗆 M 2 🗶 F Nebraska Director 075-20-8773 95 Usual Residence of Decedent should be filed within 72 hours are rand Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show if is marked other than "natural", or items 25a or 28a-f show arise event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2X No Maryland Chevy Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 7107 Pomander Lane 20815 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. ģ 1 Never Married 2 XMarried Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White 3 🗌 Widowed 4 🗋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School Teacher Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important if item 27 is marked any injury or other traumations. မှ Ethel Turk Peter J. Bentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David S. Blanchard/Husband 7107 Pomander Lane, Chevy Chase, Maryland 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 29 cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State Montgomery Crematorium. 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland Inc. 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Charlon M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Inforction Immediate Cause (Final Houte Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Jim to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phoched for use as the IF FEMALE: been signed by the attendin should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 10/26/11 Completed by Conjestive Heart failure 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? Per fension 24a. Was an After this certificate has autopsy performe Parlipidemia Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA မ Blanchard, Dorothy 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) October 20, 2011 Philip Stars, MD Subukan Hospital 8600 dd Georgeon Rd., Betterch, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Booker Alice Lucinda 11:11PM 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Aberdeen 428 Parke St. S. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours 215-40-1170 Director 1 🗆 M 2 🗶 F 70 1/12/1941 Maryland 28a-f show 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at 10b. County Director Harford Aberdeen 1 XYes 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21001 428 Parke St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force 1 Never Married 2 X Married Completed by Yes 2 No Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Longe. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medicine Nursing Assistant 9 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Ringgold George Earl, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Parke St. S. Aberdeen, MD 21001 William Booker / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Harford Mem.Gardens 11/2/2011 Aberdeen 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility Tarring-Cargo Funeral Home, 333 S. Parke St. Aberdeen, Approximate Interval Between Onset and Death 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Medical Certificate: To 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred injury 5 Pending Natural 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title **State** Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-07978 Andre L. Bover Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

nare L. Boyer	1- For State  1-	34681
Physician/	Registrar  2. Date of Death 3. Tir	me of Death
ledical Examine	Andre' Lamont Boyer October 23, 2011	818 hrs
	4a. Facility Name (if not institution, give street and number) 4319 Norfolk Avenue  4b. City, Town, or Location of Death  A319 Norfolk Avenue  A210 Norfolk Avenue  A210 Norfolk Avenue	
	4319 Norfolk Avenue Baltimore N/A  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace	e (State or
Funeral Director	218-58-7724 1 Months Days Hours Min. 08/31/1952 Foreign Country)	
any	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d.	Inside City Limits
		XYes 2 No
the Maryland  or 28s-f show  tified at once.  Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
th the Maryland 23s or 28s-f sho notified at ouce. al Director		
or items 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc.	idian, Black,
for des		k
stural"	15 Decedent Education (Specific up, highest grade completed) 16a Decedent Ellevel Decupation (Give kind of work done 16b Kind of Business/Industri	y rity
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  A years  Decision Writer  Administrat	
within giene.	Decision Writer Administrat  17. Father's Name (First, Middle, Last)  Administrat  18. Mother's Name (First, Middle, Maiden Surname)	1011
215-0036 be filed within 7 mal Hygiene. rked other in the Medican cent, the Medican Be Comple		
213 could b d Men fic eve	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	Code)
MD  1d 2 sho alth and m 27 is	Janaia Boyer (daughter) 2326 Koko Lane, Baltimore, MD 21216  20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town,	State
Ore, es lar of He If ite	1 X Burial 2 Cremation 3 Removal from State crematory or other place)	,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	4 Donation 5 Other Specify: King Mem. Park 11/01/11 Baltimore,  21. Signal of of Funeral Service Licensee 22. Name and Address of Feet Young. In Funeral Home	MD
Bal Dermi Depar Injur	21. Signatur of Funeral Service Licensee 21 Andrews of Family Own Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, M.	D 21217
Physician		proximate Interval etween Onset and
/Wedical Examiner	Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	Death
	or condition resulting in death)  Due to (or as a consequence of):	
je	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause	
ed nsit <b>Examiner</b>	(Disease or injury that initiated c. Due to (or as a consequence of):	
cuted and transit		
60, ate be executed hysician and e burial - transit	UNPENDED AMENDED	
8760 ificate ig physis the b		Year
b. Box 6876 the death certificat the attending phy y the attending phy ched for use as the Physician/M	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
. Bc he dea y the a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the ca	ause of death?
ires that the signed by a be detach	1 Yes 2 No 3 Probably	4 Vnknown
Records, The law requires ficate has been signage 2 should be Completed	24a. Was an 24b. Were autopsy autopsy prior to comple	findings available etion of cause of
ecolor le law te has ge 2 si	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check only only)	
F Vita	1 Yes 2 No 1 inpatient 2 Expourpatient 3 DOA 4 Nuising Holle 5 Residence 5 Governous	ne
ding Ph ding Ph After t funeral	1 2/ Manner of Death 120a, Date of Injury 120b, Time of Injury 120c, Injury at Work? 120d, Describe now injury occurred	
Sior Attend r death ector: by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Ro	oute Number, City
Division of spital or Attending tours after death.  Increal Director: After filled in by the fund.  Certification:	3 Suicide 6 Could not be determined (Specify)	
3-1-2-2-1	1/98 CERTINEL 1 La visa a manufacture in the state of the second of the second due to the second of and manufacture stated	150(5)
To the Howithin 24 h To the Fun completely	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.  29b. Signature and title-of certifier  29c. License number  29d. Date signed (Month, D	
2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, D  October 24, 2011	, , out/
	Name and address of person who completed cause of death (Item 23a)	
	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra	MILLY II I WILL IN A CONTROL OF STREET	-
77-7411-317-2		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HAZEL CRONEr 10:15 A M OCTUBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Seasons Hospice @ Northwest Hospital</u> Randallstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 213-09-4681 1 🗆 M 2 💢 F Director July 15, 1913 Maryland 98 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2X No Owings Mills Baltimore Marvland 10g. Citizen of What Country? 10e. Street and Number r items 23a or ner must be n ō Funeral 21117 USA 4730 Atrium Court death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status an "natural", or iter Medical Examiner Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Completed 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Fashion Illustrator Art Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Selma Alexander Sidney O. Marcus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other traumonce. 9417 Crimson Leaf Terrace Potomac, Maryland 20854 Charles M. Croner, Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 10/28/11 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Thomas Gregor 2. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final END-STANE (OPD Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) ed by the a Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The basis of examination and a minimum and a 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MsRajapalmen O D0057465 10/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21209 2835 Smim /N 5203

State Registrar N.S. Rajapakse, M.D.

NOV 0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28 2011 5:58 Constantine AM Elena Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emmitsburg 14534 Sixes Bridge Road Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 4-27-1952 Maryland 59 **Director** 212-62-9286 Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14534 Sixes Bridge Road 21727 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. "natural", or iten edical Examiner r Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White the Medical 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event" once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Supervisory Systems <u>Analyst</u> U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Constantine Estelle Dezes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21727Timothy Cliffe Husband 14534 Sixes Bridge Road Emmitsburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Greek Cemetery 11-1-2011 Baltimore Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
18 months Immediate Cause (Final Ph\_sician/ Uterine carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director, to Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \sum Yes 2 \sum No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 X Natural 5 Pending 1 Tes 2 🗆 No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 128/211

State Registrar 31. Date filed (Month, Day,

NOV O

Frederick, MD 21701

Sebastien Kairouz, M.D. 46B Thomas Johnson Drive, Suite 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g922 12-6-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Esther Μ. Colliflower Physician/ October 26, 2011 12:15 AM Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris Hospice 4c.CountyBaltimore 4b. City, Town, or Location of Death 1 MON1 UM **Examiner** 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 220-03-1013 215-34-8910 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 07/01/1916 95 **Director** 1 - M 2 - F 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 🗶 No 10f. Zip Code 21030 10e. Street and Number 10g. Citizen of What Country? 2300 Dulaney Valley Road W206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 12:15 Completed 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Volunteer 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hospice 2011 Be 17. Father's Name (First, Middle, Last)
JUIIUS BUZI 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 26, 19a. Informant's Name/Relationship (Type, Print)
Geraldine C. Ryan/Daughter 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Gode) 7300 01d Sandy Spring Ro., Laure 1, MD 20707 OCTOBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, S Beltsville, MD 10/28/2011 1 Burial 2 X Cremation 3 Removal from State Chesabe ake crematory 4 Donation 5 Other (Specify) rota Marshall 22. Name and Address of Facility Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition RENAL DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that Initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 ESTHER COLLIFLOWER IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atter in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe or Attending Physician; The Yes 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director; A 1 Yes 2 No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 3 🛣 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title/o 29d. Date signed (Mogth, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) **JONES** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature State NOV 0 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Jacquelyn Marie Clawson October 27 Physician/ 4:50 2011 a M Medical 4c. County of Death Baltimore Facility Name (if not institution, give street and number)
Stella Maris Hospice 4b. City, Town, or Location of Death Examiner Social Security Number 217-76-3157 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Davs Hours 07/22/1960 51 **Director** 1 M 2X F Yrs "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State MD 10c. City. Town or Location 10d. Inside City Limits 10b. County Director Baltimore 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 716 Springfield Avenue 10f. Zip Code 21212 Funeral death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 XXNever Married 2 Married Yes 2 X No Completed by 4:50 а.ш. Baltimore, Maryland 21215-0036 Specifelack 1 ☐ Yes 2 💢 No Specify 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last, EIMO CI awson 18. Mother's Name (First, Middle, Maiden Surname) 2011 ည 19a. Informant's Name/Relationship (Type, Print) Dashaun T. Avalon / Son . Mailing Address (Street and Number of Rural Floyte Number City 1773414. State, Zip Code) 27, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OCTOBER cemetery, crematory or other place)
Atlantic Crematory 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State 10/29/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ►Physician/ disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician dbe detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 2 X No JACQUELYN CLAWSON 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) ၉ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 30. Name and addr erson who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. JONES, CRNP <u>JACKIE</u> Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 18:55 PM Month Physician Virginia 30 2011 (+obes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2X F 214-18-2999 96 June 15,1915 Oregon **Director** Usual Residence of Decedent 10d. Inside City Limits 10a State 10h Count 10c City Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Dundalk Md. Baltimore 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21222 USA 1915 August Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after Hygiene. 1 Yes 2 If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Specify: White 3 3√ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Teacher Baltimore County 12 years 4 years 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) ges 1 and 2 should be fill of Health and Mental Hy Be Walter Mileski Helen Petrokowska ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 336 Roberts Drive, Sommerdale, NJ 08083 Barbara Siegmund Daughter permit. Pages 1 a
Department of Hee
Important: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 3, 2011 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk Md. 21222 withou Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 No 3 Probably 1 TYes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 2 No 2 No 1 ☐ Ýes 1 Tyes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၀ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury al or Attending s after death. I Director: After 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 🗌 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

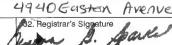
State Registrar

31. Date filed (Month, Day, Year) NOV 0 1 2011

Rapiee M.D.

Atrosa Reities

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

29c. License number RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Α. Condon 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosed timore Square Hospita 8 Date of Birth 9 Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 215-16-1465 Maryland Director 1 🗌 M 2 🛣 F 88 July 8,1923 ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Md. Joppa 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 609 Anchor Drive 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Sign Company 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James J. Rock Reba M. Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Snyder Daughter 609 Anchor Drive, Joppa, Md. 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) November Dundalk, Maryland Donation 5 Other (Specify) Christ Lutheran Cem. 4, 2011 21. Signature of Funeral Service Licens Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, shock, or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Physician/ disease or condition 7 days Medical resulting in death) Examiner umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): and as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Melli Diabetes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pauline Euther Colbert 7:45 PM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. **Funeral** ocial Security Numbe 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country June 23, 1931 215-28-3053 Days Hours Min. **Director** 1 □ M 2 😾 F 80 ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Y Yes 2 No 10f. Zip Code 21217 10e. Street and Number 10g. Citizen of What Country? 1807 N. Payson St. by Funeral er than "natural", or items the Medical Examiner πυ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 XNo Yes Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Give 3

Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 2 should be filed within 72 in and Mental Hygiene. State of Maryland life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Food Service Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev မှ Louis Taylor Pauline Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ralto, Md. 21218 19a. Informant's Name/Relationship (Type, Print) Brenda Boyd (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cem. Nov.3,201 Balto.Co,Md 4 Donation 5 Other (Specify) 21 Phnatur of Funeral Service License Callwin Ades of Schuggs Funeral Home Preston St. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ urosepsis <u>days</u> Medical resulting in death) Due to (or as a o nsequence of) Examiner Respiratory Sequentially list conditions if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 / No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/28/11 AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yaghi-Union Memorial Hospital-201 E. University PKWY, Baltimore MD State

Registrar

11-07610 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physic	ian/	*								3. Time of Death	
vieuicai ⊑xan	ime	Yvonne Cosby  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death								0255 hrs	
		3000 Blk. Reisterstown R		N/A	o Deau						
Funera		3000 Blk. Reisterstown Road Baltimore N / A  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY									
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Maryland 28a-f show d at once.	<u> 5</u>	MD N/A				Ltimore	9			1 X Yes 2	No
Mary r 28s-	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of Wh	•	
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leath with the Maryland titlems 23a or 28a-f she ust be notified at once.	Funeral	11. Marital Status  1 X Never Married 2 Marrie	12. Was Decedent Eve Armed Forces?	er in U.S.		cedent of Hispar pecify Cuban, Me		pecify Yes or No Rican, etc.)	- 14. Race White	- American Indian, Black, , etc.	
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5–0036 led within 72 hours at Hygiene, other than "natural the Medical Examin	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of	working life. DO	NOT use ret	ired)		·	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Abraham Cosby  19a. Informant's Name/Relationship (		Lie				McCra			
U gg B m A	ြင									n, State, Zip Code)	,
7 8 5 5	-	Bernice Johnso 20a. Method of Disposition	n(sister)			Name of cemete		Date		, MD 21133 City or Town, State	-
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/Medical Examine			Multiple Injuries							Between Onset : Death	and
Adiiiiiei		or condition resulting in death)	Due to (or as a conseque	ence of):							
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od sit	Xa.	events resulting in death) Last	Due to (or as a conseque	ence of):						-	
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760, icate be execut physician and the burial - tra	/Medical								Too.		
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	r pregnancy 2	Fetal de	ath 3 E	Ectopic pregna	ancy	23d. Date of o Month	lelivery Day Year	
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Division tal or Attendii rs after death.	fica	2 Accident Investigat 3 Suicide 6 Could not	28e Place of Injury	- At home, fa	m, street, fact	ory, office buildi	ing, etc.			or Rural Route Number, (	City
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 42 thours after death. Funeral pierctors: After this certificate has been signed by the attending lely filled in by the funeral directors, page 2 should be detached for use as	Certification:	4 Homicide determine		Road / Hig	ghway			or Town, St 3000 Blk. Reis	tate) sterstown Road	Baltimore, MD	
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Division  To the Hospital or Attend within 24 hours after death, To the Funeral Director: completely filled in by the 1	Medical		On the basis of examina and manner stated.	tion and/or in	vestigation, in			t the time, date a	and place, and du	e to the cause(s)	
	≊	29b. Signature and title of certifier	1/ 11			29c. License nu				(Month, Day, Year)	
		Mellin Bra	soll MD			O.C.M.E			October 11,	2017	
).		30. Name and address of person who Melissa Brassell, MD A	completed cause of death ssistant Medical Ex	ominor (	900 W Bo	Itimore Stran	et Raltimo	re MD 2422	3		
	tate			ignature 4	are	umore Street	Dailillio	16, IVID 2122	J		-
Regis		31. Date filed (Month, Pay Year) NOV U 1 201	1 Registrar's S	19.19	and						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State Registrar	Ce	rtificate of D	eath		Reg. No. 2 0	1 21.60
Physici		1. Decedent's Name (First, Middle, Last)  Josephine Hill	Carte	er		2. Date of De	r 26, 201 <sup>Y</sup> 1 <sup>ar</sup>	3. Time of Death 5:10 PM
Medi Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County of Dea	ath
Funeral			(In yrs. last birthday)	If Under 1 Year Months Days	rville  If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	Montgo	Sirthplace (State or Foreign Country)
Director	1.	579–28–9773	94 Yrs.	a cation		February	15,1917	Virginia  10d. Inside City Limits
faryland <b>Ba-f sh</b> <b>Lified a</b>	Funeral Director	Maryland Montgomery	Tue. City, fown or Le		ckville			1 ☐ Yes 2 🔯 N
h the Manager 28	al Dir	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	
ems 23	uner	10500 Rockville Pike, Apt.  11. Marital Status 12. Was Decedent E		Was Decedent of His If Yes, specify Cubar	0852 spanic Origin? (Sp	ecify Yes or No-	United 14. Race - Am	
e filed within 72 hours after death with the Maryland ttal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 3 🖫 Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 📆 If Yes, Give Year or Dates.	No	If Yes, specify Cubar  1 ☐ Yes 2 X No		Rican, etc.)	Specify	White
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nd 2 sh ealth a m 27 is ner tra		Christopher L. Carter / So	n 3952	Forest V			timore, Mar	cyland 2123
permit. Page 1 and Department of Heal Important: If item any injury or other once.		20a. Method of Disposition  1   M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disponent Arlingto	osition (Name of ematory or other place on Nationa netery	Janua 20	ary 4, 012	20c. Location - City of Arlington	
permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee	Ŕ	Cobert and Adres	nphreijy Fun	eral Home Bethesda	/Bethesda-Che Maryland 208	evy Chase, Inc 314–3501
Physician Medica Examine		resulting in death) Due to (or as a	e. liac Arres a consequence of):	t			rest,	Approximate Interval Between Onset and Death Minutes
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical Certificate: To Be Completed by	Part II. Other significant conditions contributing to death by  Idiopathic Pulmonary Fibro  Cognitive Disorder  25. Was case referred to medical examiner?  1 Yes 2 X No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 X Certifying Physician: To the basis of examiner: On the basis of examiners of the same and t	ut not resulting in the OSIS  ent 2 ER/Outpatie ry 28b. Time of injury  ary - At home, farm, sto. (Specify)  my knowledge, death xamination and/or inve e best of my knowledge	Other (specify)  underlying cause giv  26. Pla  and 3 DOA  of 28c. Injury work 1 1  treet, factory, office  a occurred at the time stigation, in my opinic le, death occurred at ti	en in Part I.  ace of Death (Checker: 4  Nursing Harat? Yes 2  No	24a. Was auto perf 1 Ves ck only one)  Rome 5 X Res  28d. Describe  28f. Location (City or To	tobacco use contribute  Yes 2 X No 3   an propression of the cause (s) and manner as and place, and due to the cause (s) Date signed (More and and place). The cause (s) and manner as and place, and due to the cause (s) and manner as and place and the cause (s) and manner as and place and the cause (s) and manner as and place and the cause (s) and manner as and place and the cause (s) a	Day Year  Ito the cause of death?  Probably 4 Unknow autopsy findings available to completion of cause or?  Yes 2 No  Pecify)  Pural Route Number,  stated.  the cause(s) and manner start as stated.  Inth, Day, Year)
nding Physician: The law requires that the de ath. r: After this certificate has been signed by the ie funeral director, page 2 should be detached	edical Certificate: To Be Completed by	Part II. Other significant conditions contributing to death by  Idiopathic Pulmonary Fibre  Cognitive Disorder  25. Was case referred to medical examiner?  1 Yes 2 X No  27. Manner of Death 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check 2 Medical Examiner: On the basis of exonly one)  1 Certifying Physician: To the basis of exonly one)  1 Pregnant at 9 Pregnant at 9 Unknown  4 Pregnant at 9 Pregnant at 9 Unknown  5 Conditions Could not be determined  28a. Date of injunctions Death (Month, Day building, etc.)	ut not resulting in the OSIS  ent 2 ER/Outpatie ry, (Year) 28b. Time of injury  any - At home, farm, st. c. (Specify)  my knowledge, death xamination and/or inve e best of my knowledge et and for inverse control of the control of t	Other (specify)  underlying cause giv  26. Place of 28c. Injury work 1 1 treet, factory, office occurred at the time stigation, in my opinice, death occurred at time 29c. License 1000	en in Part I.  ace of Death (Checker: 4 \sum Nursing Heat? Yes 2 \sum No  a, date and place, n, death occurred ne time, date and place in number  63156	24a. Was auto perfit I Ves ck only one)  Rome 5 X Res  28d. Describe  28f. Location (City or To and due to the cat the time, date blace, and due to	tobacco use contribute  Yes 2 X No 3   an psy ormed? 2 X No 3   clearly ormed? 2 4b. Were a prior to death' 1	Day Year  Ito the cause of death?  Probably 4  Unknown under the cause of c

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10/29/2011 Physician/ 1:15 Ам William Gormon Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Sunrise of Columbia Columbia . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min Months 1/2/1933 246-48-1921 78 North Carolina Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No West Friendship Maryland Maryland Howard 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A. 21794 3170 Danmark Drive hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married X Yes 2 No þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Army Specify Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NSA Systems Analyst Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Josephine Reel Noah M. Davis permit. Page 1 and 2 should be Department of Health and Menf Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Davis Jr. - son Jacksonville, FL 32259 2030 Grove Bluff Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Marriottsville, MD 4 Donation 5 Other (Specify) Crestlawn Memorial Gardens 11-2-2011 22. Name and Address of Facility Witzke Funeral Homes 5555 Twin Knolls, Rd 21. Signature of Funeral Service Lic. all 1 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 Years Immediate Cause (Final Ph\_sician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) nding physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Month Dav Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Pneumonia 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate has 1 Yes 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? ASSISTED Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) Living 1 🗌 Yes 2 🛚 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this hours after death. neral Director: After this d filled in by the funeral o 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

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Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, 8600 Snowden River Parkway

NOV 0 1 2011

m D

. Registrar's Signa

29c. License number

D56531

Columbia, MD 21045

29d. Date signed (Month, Day, Year,

October 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2່ທີ່ໄ 6:50A M John Thomas Duvall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Glen Burnie 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 1 M 2 F Dec. 5, Days Hours Min 220-70-0061 **5**1Yrs 'Î'959 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1770 Simms Lane 21076 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Irvin Robert Duvall Betty Elizabeth Cronmiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Duvall/ Brother Simms Lane, Hanover, Maryland 21076 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1💹 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 31,2011 Elkridge Maryland Meadowridge Mem. ParkOct. 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Signature of Funeral Service Licen 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 9781. W. 24 Obstr Physician/Medical Examiner Medical Certificate: To Be Completed by

Physician/ Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 been signed by the a should be detached t has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked of other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Department of H Important: If ite any injury or ot once.

Baltimore, Maryland 21215-0036

resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or se a consequence of):		
that initiated events resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	//	23d. Date of delivery Month Day Year
	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Comman)	of ordered Enguesa	1 X Yes	2 No 3 Probably 4 Unknown
Mrons.	engyclose	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
forling	to thrive	performed?	death?
25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)	
1 ☐ Yes 2 No	lospital: 1	lome 5 🗆 Residence	6 Other (Specify)
27. Manner of Death  1 Autural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
(Check 2 Medical Examin	cian: To the best of my knowledge, death occured at the time, date and place, a ler: On the basis of examination and/or investigation, in my opinion, death occurred Practioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and place	ce, and due to the cause(s) and manner stated.

D 63721

NO LEC

alun

29d. Date signed (Month, Day, Year)

1105,87,001

State Registrar 29b. Signature and title of certif

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30, October Lou Dearborn 2011 Betty 4:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Edenwald Baltimore TOWSON
ear I If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Nov. 8, 1930 **Funeral** 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 1 D M 2 X F Hours Months Days North Dakota **Director** 80 473-28-6054 iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road 21204 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: White 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Police Dispatcher Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabelle Grant Swensgard Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 Stratford Road Kensington, CA Wendy Kaufman Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 11-1-2011 Maryland Towson 22. Name and Address of Facility Ruck Home, 21204 Towson Funeral 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate val Retween Immediate Cause (Final disease or condition and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregp 23d. Date of delivery 3 Ectopic pregnancy in the past 12 detached for Month Day Year Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 3 Probably 4 Unknown 1  $\square$  Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 20 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) ျင 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pendina work? Investigation 2 🔲 No Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a completed filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 [ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Sia nature and title of cer who come me and address of p

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ Ronald James Dieter Sr. lo 01:35 A M 11 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WICOMICO Coastal the ake alishury - at HOSPICE If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 212-36-1807 Country Hours 1 192971 940 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. Count 10a. State 10c. City, Town or Location Director Berlin Worcester 1 Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 21811 10e. Street and Number Funeral Keel Drive 15 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status was becedent Ever in O.S.
Armed Forces?

1XXYes 2 □ NoNational
If Yes, Give Guard
Year or Dates. Black, White, etc. þ 1 Never Married 2XX Married Konald Julter altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Engineer Be 18. Mother's Name (First, Middle, Maiden Surname)
Rosa Bissell 17. Father's Name (First, Middle, Last) 2 Henry Dieter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Keel Drive, Berlin, MD 21811 19a Informant's Name/Relationship (Type, Print) Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 10/31/2011 1 Burial 2XXCremation 3 Removal from State Chesabeake Crematory Beltsville, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
P0 box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cance disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death owithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the atter in the past 12 months? cate has been signed by the atte page 2 should be detached for Month Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Division of Vital Records, 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed death? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner's Other: 4 Nursing Home 5 Residence Other (Specify) HUSP 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certiful 06319 30 0 ddress of person,who completed cause of death (Item 23a) (Type, Print) 30. Name and 910 OHRA EASTERN SALISBURY 21804 OCKE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0

32.

Registrar's Signature

State Registrar

Box 68760

P.O.

Records.

Kim Boswell

31. Date filed (Month, Day, Year) NOV 0 1 2011

University of Maryland 22 S. Green St. Baltimore, M.D 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeith O Edwards, 3:30 p м Medical October. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1217 Abinchar Drive Harford Abingdon 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1**X** M 2 □ F Months Days Hours Washington, DC Director 215-40-5628 70 Aug. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Harford Abingdon 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1217 Abinchar Drive 21009 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ò 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Floor Mechanic Building Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Owen Edwards Sr. Nancy Ann Cissel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Catherine M. Edwards/Wife 1217 Abinchar Drive, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-29-11 Towson, Maryland ture of funeral wice una 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death End Ph sician/ End Stage C Due to (or as a con-equence of): disease or condition resulting in death) COPD Medical **Examiner** Hobecco abuse Sequentially list conditions, if any, leading to immediate Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASCU O Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an anemia performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. D31295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 Kenward Ave mo 31. Date filed onth, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep	artment of Health and l rtificate of Death	Mental Hyg	jiene	
			Registrar  1. Decedent's Name (First, Middle, Last)	Timcate of Death	2. Date of Deat	th 20	3. Time of Death
	Physicia Medic		Cornelius J. Edwards		Month Octobe	r 28, 2011	
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	eath
	f 		3658 Gleneagles Drive 5. Social Security Number   8. Sex   7. Age (In vrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	T 0 Date of Dieth	Montgome	
	Funeral Director		1 X M 2 □ F	Months Days Hours Min.	8. Date of Birth (Month, Day, July 7,	Year) 1921 Nev	Birthplace (State or Foreign Country)  Jersev
		8	Usual Residence of Decedent		DULY 1,	1321 11100	
	yland -f sho ed at	ctor	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	e Mar r 28a notifi	Dire	MD Montgomery Silver Sp	ring   10f. Zip Code		10g. Citizen of What	1 🗆 Yes 2 💢 No
	vith th	Funeral Director	3658 Gleneagles Drive	20906		USA	oound y :
	eath v terns er mu	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sr	pecify Yes or No-		nerican Indian,
9	ifter d ", or i	by	1 ☐ Never Married 2 ☐ Married 1 🔀 Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto  1  Yes 2  No Specify:	o nican, etc.)	Black, Wh Specify: <b>W</b>	
2-002p	ours a atural cal Ex	Completed	Year or Dates. 1942–45	dent's Usual Occupation			
<u>.</u>	יי 72 h an "ni Medii	ldw	(Specify only highest grade completed) (Give	kind of work done during most of wor OO NOT use retired)	king	16b. Kind of Busines	ss industry
Z	withii giene <b>er th</b> <b>t, the</b>			Vice President		Advertisin	ng
yland	e filed tal Hy ed otf	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar <b>Corinne</b>	ne (First, Middle, f	Maiden Surname)	
Ž	d Mer mark matic		John Kip Edwards  19a. Informant's Name/Relationship (Type, Print)  19b. Mail			Officer Terror Otata	Zin Coda)
<u>a</u>	12 shouth an an and an an and an an an and an an and an			ing Address (Street and Number or Ru Reservoir Road F	ulton, M	D 20759	Zip Code)
ē,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	20a. Method of Disposition 20b. Place of Disp	osition (Name of matory or other place)	Date	20c. Location - City	or Town, State
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Final Jou	rney Crematory 10	/29/11	Woodbine,	MD
baitimor	ermit. eparti nport ny inj	j	21. Signature of Funeral Service Ligenses	2. Name and Address of Facility Oing Home Cremati	on Servi	ce P.O. I	3ox 784
_	⊕ □ = @ O			everly L. Heckrot	to PA	Clarksvi	Lle MD 21029
ı	Di		shock, or heart failure. List only one cause on each line.		or respiratory arre	551,	Approximate Interval Between Onset and Death
The same	Ph_sician/ Medical		disease or condition resulting in death)  Ischemic Cardiomy  Due to (or as a consequence of):	opathy			-
	Examiner						
	ъ ±	ine	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				4
	ecuted and trans	Examiner	Cause (Disease or iinjury that initiated events c				
2	cate be executed physician and the burial-transit	edical E	d d				
2/00/	ficate g phy as the	Medi	To see the see that the see tha				
SO X	h cert tendin r use	Physician/M	FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3	☐ Ectopic pregnancy		23d. Date of	
POX	e deat the at hed fo	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)		Month	Day Year
л Э	hat the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
S,	uires t n sign Ild be	ed by			1 🗆 Y	′es 2 □ No 3 □	Probably 4 🛚 Unknown
5	w request special spec	plet			24a. Was a		autopsy findings available to completion of cause of
Records,	The la ate ha page ;	Completed			perfor	med? death	
N La	cian:	Be	25. Was case referred to medical examiner?	26. Place of Death (Che			
<u> </u>	Physic this cral dir	2	1  Yes 2  No 1 Inpatient 2  ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of			ence 6 Other (Sp ow injury occurred	ecify)
	nding ath. !: After	icate	1 XNatural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work?  M 1 \( \superset \text{Yes}  2 \superset \text{No} \)	Zod. Describe in	Sw Injury Goodifica	
DIVISION OF	r Atter er dez rector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	treet and Number or i	Rural Route Number,
É	ital or aft ral Di						/
	Hosp 24 hor Fune eted fi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation)	stigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the	ne cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 \(\subseteq \text{Certifying Nurse Practioner:}\) To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and plant 29c. License number		cause(s) and manner 29d. Date signed (Mo	
			1 (Ben V)	D37142		October 28	3, 2011
ار			30. Name and address of person who completed cause of death (Item 23a) (Type,				
1	\		G. Coleman, M.D. 1355 Piccard Drive		le, MD 2	0850	
	Stat Registra		31. Date filed (1971) Day, 23011 32. Registrar's signature				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Charles 0. Edwards Physician/ October 29, 2017 8:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or oction of Death Ball Lillione **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, Year) 06/11/1943 9. Birthplace (State or Foreign Country) Social Security Number 249-64-3520 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday Days Mir 68 Director 1 🕱 M 2 🗆 F Yrs or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore 1X Yes 2 □ No 10e. Street and Number Central Avenue 10f. Zip Code 10g. Citizen of What Country? 21231 Funeral items 23a USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. "natural", or 9 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Mover Service Be 17. Father's Name (First, Middle, Last)

Joseph Edwards 18. Mother's Name (First, Middle, Maiden Surname) ျှ Lucille 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Ventnor Terrace, Baltimore, MD 21222 <sup>19a.</sup> Informant's Name/Belationship *(Type, Print*) Angela E. Cureton / Daughter permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Glen Burnie, MD 10/31/2011 1 Burial 2 X Cremation 3 Removal from State At 1 amtar*ci*ectematorise) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Fagility Cremation Services PU box 1413, baltimore, MD 21203 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atter d be detached for Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed' 2 No Yes 2 NO 1 Yes the Hospital or Attending Physician: filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 은 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and ti 10 D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NCHARLES ST SUTTGIOS RALTIMORE 31. Date filed (Month, Day, Year) State NOV 0 1 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:00 PM Physician 201 10 Fordell Jo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rose dale Under 1 Year | If Under 24 Hrs. Square 6. Sex HOSPIta ranklin Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 S F Director 212-48-8219 09/25/1948 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, Ite Nedical Examiner must be notified at 1 ☐ Yes 200 No Director MD Baltimore Rosedale 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 6 Breslin Court, 21237 U.S.A Funeral Apt. 1A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens important; if Item 27 Is marked other the any lijury or other traumatic event, Ite. 2008. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown 2 Verbus Martha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vincent M. Fordell 6 Breslin Court, Apt. 1A, Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 10/31/2011 | Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licencee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 □ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has be 2 s autopsy certificate 2 □ No 1 □Yes 2 No 1 Yes : After this certifical e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N. Occisrani 16064167

DHMH 17 Rev 1/2001

State

Registrar

9000 Franklin Square Drive Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

israni

32. Registrar's Signature

Qa

Noshin

31. Date filed (Month, Day, Year)

NOV 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 28, Geneva Dean Finney 2011 7:22 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Director 214-30-5668 Yrs Maryland 1932 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 A Yes 2 ☐ No Maryland Harford Havre de Grace 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Apt. 709 505 Congress St. 21078 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 XNo within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. "natural", 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Parts Store 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o မ Mack Coy Moxley Octavia (unk) Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important; If item 27 is any injury or other trauonce. Mack Coy Moxley / Brother 2823 Forge Hill Road, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn : 11-5-2011 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signatute of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final avdia Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Car Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical  $\mathcal{G}_{\mathcal{L} \mathcal{N} \mathcal{K}} \mathcal{N}_{\mathcal{K}}$  Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery atten for u in the past 12 months?
1 Yes 2 No Month Year Day the i 9 Unknown 9 Unknown ned by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has b lirector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 ဂ္ 1 Inpatient ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 8b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural
Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signa 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2027 Pulaski Hwy, Havre de Grace, Maryland 21078 Robert Edmund Rapp, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1230 CONNIE C. FURLONG ,2001 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death HART HOME HAVR DE Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗆 M 2 🖫 Months Hours FEB. 21 Country) MD Director 84 214-20-9493 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: In item 27 is marked of other than "naturalic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director **EDGEWOOD** MD HARFORD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 EMILY DR 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) GOETZ MEAT Elementary/Seconday (0-12) College (1-4 or 5+) PACKING LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ANGELINA ORONATO LUCIANO DELL'ACQUA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1900\ EMILY\ DR\ EDGEWOOD$  , MD 21040EUGENE FURLONG-HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/2/11 BALTIMORE, MD HOLY REDEEMER CEM. of Funeral Service Licens 21. Signatur 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR 610 W.MACPHAIL RD BEL AIR, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death each line. shock, or heart failure. List only one cause Immediate Cause (Final Physician. disease or condition resulting in death) Medical Du- to r as a consequence of Examiner Sequentially list conditions If any, leading to immediate Cause (Disease or linjury bunial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregran in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) Month Day Vear Pregnant at time of death g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 A Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Man of Death Certificate: 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 - Pending injury work?
1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide dermined City or Town, State) within 24 hours a To the Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated e and title of certifier 29d. Date signed (Month, Day, Year) Z8 mn Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Octobe Day 37 PM moth 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HMore Johns Hopkins Date of Birth (Month, Day, Year) If Under 9. Birthplace (State or Foreign **Funeral** Hours 215-44-1999 Director 1 XM 2 □ F Yrs. 64 March 2,1947 Maryland show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Baldwin Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21013 14510 Green Road USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 1967 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Gracey Marie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Carol D. Gracey, Wife 14510 Green Road Baldwin, Maryland 21013 other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of i Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 10/28/11 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland Funeral Service Licens (Thomas Gregor Signature of Cremation Society Of Cary 299 Frederick Road Baltimore, Name and Address of Facility
emation Society Of Maryland, Inc Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Pulmonary Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical Box 68760 the attending IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Hospital or Attending Physician: The law requires that the death Month Day Year 9 Unknown Division of Vital Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2 No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Rtite 30. Name and address of person and address of person who completed cause of death (Item 23a) (Type, Print) Hetgeson 6000 N. WOLFP

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1	1 - State Registrar Certificate of Death Reg. No. 2											34706			
		Physicia	in/	Decedent's Name (First, Middle)	Last)						2. Date of De Month		ay	Year	3. Time of Death
		Medic	cal	David Theodore  4a. Facility Name (if not institution,		-1		4b. City, Town,		- ( D 1)	10	20		2011	10:30 P <sub>M</sub>
		Examin	ıer	Stella Maris	/			or Location on the control of the co	or Death		40	c. County		imore	
		Funeral				Age (In yrs. la	ast birthday)	If Under 1 Year	If Under		8. Date of Bi			9. Birthpi	ace (State or Foreign
		Director		122-36-4642	1 <b>X</b> ] M 2 □ F	66	Yrs.	Months Days	Hours	Min.	(Month, Di	ay, Year) 24 19	945	New	York
		nd now at	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	ation						10	0d. Inside City Limits
		anylar a-f sl	Director		timore		,,	Pikesv	ville						1 🗆 Yes 2 🔀 No
		or 28	盲	10e. Street and Number				10f. Zip Code				10g. C	itizen of \	What Count	ry?
		within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	1338 Greenbrian	Circle				21208			Ţ	United States		
a.		death item		11. Marital Status	12. Was Deceden Armed Forces		5. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			14. Race - American Indian, Black, White, etc.	
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2	Ž	should to and Me		19a. Informant's Name/Relationsh			10h Mailin	g Address (Street	t and Numbe	or or Puro				tata Zin C	ada)
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[OB]	Ĕ	Page ment o tant: If ury or		1 ☐ Burial 2 ☑ Cremation  Donation 5 ☐ Other (S <sub>i</sub>	oecify)	.6	**	matory ]	· ·	10–3	1-2011	B	altir	nore l	Maryland
OCTOBER	Baltimore,	permit. Page 1 al Department of H Important: If itel any injury or ott		21 Signature of Huneral Service Li	censee 2										aryland INC
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	١,			shock, or heart failure. List or	nly one cause on each li	ine.	i. Do not ente	the mode of dyl	ng, such as	cardiac o	i respiratory a	rest,			Approximate Interval Between Onset and Death
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		n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	ence of):								
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国 国	20x 68/	eath certifica attending pl	Sup.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnan	1CV				23d. Da	te of deliver	y
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	<u>a</u>	ian; T rtifica ctor, p		25. Was case referred to medical examiner?				26. F	lace of Deat	th (Check		2 <b>A</b> IN	0	I ☐ Yes 2	Z L NO
	5	hysic his ce al dire	잍	1 Yes 2 X No			ER/Outpatient	3 □ DOA Oth	ner: 4 🗆 Nu	ırsing Hoi	me 5 🗆 Resi	dence (	6 <b>X</b> Othe	er (Specify)	HOSPICE
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		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  with the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		Physician: To the best of caminer: On the basis of										
		the lithin 2 the l		only one) 3 X Certifying 29b. Signature and title of certifier	Nurse Practitioner: To t	the best of m	y knowledge,	death occurred at	the time, dat	te and pla	ce, and due to	the caus	e(s) and m	nanner as st (Month, D	ated.
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-		<i>i</i> ,		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type, Pr	int)	111			- /	121	1	
		6 V		JACKIE JONES,	. 1 6			LLEY RD.	TIM	ONIU	M, MD	2109	3		
		Stat Registra		31. Date filed (Month, Day, Yéar)  NOV 0 1	2011	krar's Signati	1. ba	Med							

11-08093 Robert Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Green	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Registrar
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  Og 10 brown
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral	Sinai Hospital Baltimore N/A  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	214-56-2779   1 Months Days Hours Min. 3/13/1950   Foreign Country) Maryland
any.	Usual Residence of Decedent  10a. State
Maryland 28a-f show 1 at once.	Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country?
the Maryland a or 28a-f sh diffed at once	101 Ridgewood Road 21210 U.S.A.
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  unt. If item 27 is marked other than "martural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	
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5-0036 ed within 72 hour of yegiene. other than "natt the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Lawyer Attorney
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Compile	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Richard H. Green  Elizabeth Belknap
D 2121; should be fii nind Mental I 7 is marked natic event, To Be	19a. Informant's Name/Relationship (Type, Print)  Robin Lee West / Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  101 Ridgewood Road Baltimore, Maryland 21210
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other transmati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
timol t. Pages trunent of rtant: I	Hilltop Serv. Corp. 10/31/2011 Towson, Maryland
Bai permi Depar Impo injur	21 Stepnature of Funeral Service Licensee 222 Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204
Physician (Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Occlusive Coronary Thrombus
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Occlusive Coronary Thrombus  Due to (or as a consequence of):
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ords, P w requires the requires to should be defered be designed.	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach sertification: To Be Completed by P	autopsy prior to completion of cause of performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical 26. Place of Death (Check only one)  examiner?  Uther The spiral to
ing Physi After this funeral dir	27 Magnet of Death 28a Date of Injury 128b Time of Jojury 28c Jojury at Work 2 28d Describe how injury occurred
Sion Attendit death. cctor: A by the fu	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending nours after death. neral Director: After filled in by the function:	Suicide 6 Could not be 4 Homicide Could not be determined (Specify)
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the behalfed for the funeral Certification: To Be Completed by Physician/Me	
To Kill	
	O.C.M.E. October 29, 2011  30. Name and address of person who completed cause of death (Item 23a)
8	Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registra	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State o	of Marylan	•	rtment of H		Mental Hy	giene		
			1 - State Registrar Certificate of Death Reg. No. 2 3 3 3									
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month Day Yette Jauan Gardner  10 26 201									3. Time of Death
	Medic	al	Yvette Jan  4a. Facility Name (if not institution	1 " (5 "	10	26	2011	9:37 P M				
	Examin	er	6030 Park lane		iber)		4b. City, Town, or District				ounty of Death	raala
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	g. Birthn	lace (State or Foreign
	Director	Ш	577-98 <b>-</b> 0469	1 □ M 2 🖾 F	48	Yrs.	Months Days	Hours Min.	0 <sup>(Month</sup> 2 <sup>n</sup>	I <sup>y, Year)</sup> 196:	3 Count	DC DC
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1400	tems er mu	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13. V	as Decedent of His	spanic Origin? (Sp	ecify Yes or No		Race - America	an Indian,
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ם ו	al Hyg	Be (	17. Father's Name (First, Middle,	Last)		•		18. Mother's Nan	ne (First, Middle	, Maiden Sun	name)	
Maryland	Ment Ment arke	မ	Douglas Ga	rdner				Margare	t	Clark		
Mar	shous and is m		19a. Informant's Name/Relations			1	g Address (Street a			-		
6	and z Health em 2 ther t		Regina Smith/S: 20a. Method of Disposition	lster	205 5		Rooster I	ane For	t Washi		<u> </u>	
Baltimore,	permit. Fage I and 2 should be med within 7.2 hours aliet death with the waryand permit. Page I and 2.2 should be med within 1.2 hours and pergrament of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 3	1 Burial 2 TCremation		State C	emetery, crem	atory or other place		Date	1	tion - City or To	
֓֞֜֞֜֜֜֜֜֞֜֜֞֜֜֞֜֜֜֡֓֓֓֓֡֜֜֡֡֡֡֡֡֡֡֡	artme artme ortan injury		4 Donation 5 Other (		Met		tan Crema				andria, Euneral	
g	Imp any onc		N/M/K)	71000	runh		308 Suit1					Home
П			23a. Part 1. Enter the disease, o shock, or heart failure. List	complications that o	caused the deatl	h. Do not ente	r the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate
P	h sician/		Immediate Cause (Final disease or condition			.1 0					. 7	Interval Between Onset and Death
	Medical		resulting in death)	a. Due to	or as a consequ	uence of):	ancer					months
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Ţ	sit	nin	if any, leading to immediate cause. Enter Underlying	Due to (								
4	and I-tran	Exal	Cause (Disease or impury that initiated events resulting in death) Last	c. Due to	or as a consequ	uence of):						-
<b>a</b>	physician and the burlal-transit	edical Examiner		d								
376U	g phy as the			7								
3	endin use	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna Birth 2 - Feta		Ectopic pregnanc	v		23d	I. Date of delive	ery
RO RO	he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown		nant at time of o		Other (specify)				Month	Day Year
P.O. Box 68	t by tl	Phy	Part II. Other significant conditi	ons contributing to d	eath but not res	ulting in the ur	nderlying cause giv	en in Part I	ngo Did i	lah sasa usa		e cause of death?
ָרָ יָּ	signed   be d	l by	Tat in other organization	one continue and to a		and give and an	adding dadde giv	orritt die i.				ably 4 Unknown
rds	peen :	etec		in or								ssy findings available
	has b	Completed							24a. Was auto perf	psy ormed?	prior to cor death?	npletion of cause of
ľ Å	fficate or, pa		25. Was case referred to medical		-		26 Dia	ace of Death (Chec	1 🗆 Yes	2X No	1 🗌 Yes	2 🕅 No
Vital Records,	s cert directi	To Be	examiner? 1 ☐ Yes 2 🙀 No	Hospital:	Inpatient 2 🗆	ER/Outpatien	Othe			idence 6 🕅	Other (Specify)	Sister's
10	erthi erthi		27. Manner of Death	28a. Date		28b. Time of injury	28c. Injury work	at	28d. Describe			Home
ou	eath. or: Aff	fica		gation	, Day, Your	,,,,,,		Yes 2 No				
Division of	fter di irection by t	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	28e. Place	of Injury - At ho ng, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location ( City or To		umber or Rural	Route Number,
בֿ בֿ	To the hospital or Attending Frighting.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.		29a. Certifier 1 X Certifyin	Physician: To the b	eet of my line -	ladge death -	coursed at the time	date and place	ad due to the	21100/01 0== -	annor en -1-1	
3	Fun eted	Medical	(Check 2 Medical		sis of examination	n and/or investi	gation, in my opinio	n, death occurred a	t the time, date	and place, and	d due to the cau	se(s) and manner stated.
4	within To the compl	Σ	only one) 3 L Certifyin 29b. Signature and title of certifie		to the best of my	y Milowiedge, d	29c. License		oo, and due to tr		gned (Month, E	
	-, 0		Kynthia?	n Dull	com	a D	Н0058	3032		10/31	/2011	
	nı		30. Name and address of person	who completed caus	e of death (Item	23a) (Type, P	rint)					
	3V		Cynthia M. Wil	li <u>a</u> ms 3720	Upton	Street	NW Wash	ington, I	C 20016	5		
	Stat Registra		31. Date filed (Month, Day, Year)	1 2011 32.	egistrar's Signat	ture.	all					
	negistra	el .			4							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:00 PM October 29, 2011 Marthe Marie Griglio /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carriage Hill Bethesda Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖸 F Yrs. 577-40-9329 90 June 18, 1921 Canada Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 TNNo Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 10714 Kings Riding Way, #102 20852 "natural", or items 23a France Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after anet of Health and Mental Hygiene. Internal Fit Item 27 is marked other than "natural", or ite any or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine or other 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent French Embassy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victor Ouellet Alice Savard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annick G. Kittka/Daughter Department of Health Important: If item 27 any Injury or other tr once, 7522 Westlake Terrace, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition November 1 Crematorium, Inc. 2011 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

18. death. Do not enter the mode of difference of the mode of the mod 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee log the 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE HEART CONGESTIVE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🖼 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed hours af er within 24 hours a To the Funeral C completely filled i

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110 Molecular Drive, Rockville, Maryland 20850 Truong Bao, MD

Zurano, mo

31. Date filed (Month, Day, Year) NOV 0 1 2011

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO057124

29d. Date signed (Month, Day, Year)

10/31/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 2011 Physician/ 1:50 PM am S Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Bultimore etimore esuick 0 Social Security Number Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 7. Age (In vrs. last birthday, **Funeral** Months Min 1 ★M 2 □ F Days Hours **Director** 10-29-1919 OHIÓ 91 287-16-1550 Usua 28a-f show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location aţ Director 1 ¥ Yes 2 ☐ No notified Baltimore Maryland Baltimore CIty 10e. Street and Number 10f. Zip Code 21229 ō 10g. Citizen of What Country? ıral", or items 23a o Examiner must be 4727 Amberley Avenue United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Black "natural" Completed 3

Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Longshoreman <u>Laborer</u> 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sarah A. Brown Richard W. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denver Harris - SON 4727 Amberley Avenue, Baltimore Maryland 21229 20a. Method of Disposition 20c. Location - City or Town, State 20b Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Metro Crematory INC 10-31-2011 Baltimore Maryland Other (Specify) Donation 22. Name and Address of Facility Cremation Society Of Maryland INC 21. Si ature of Fune 299 Frederick Road, Baltimore Maryland 21228 eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Dement disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialsate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2X Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No ᅆ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1XXNatural  $5 \square$  Pending injury work within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Ecertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tix 29d. Date signed (Month, Day, Year, R174141 2011 se of beath (Item 23a) (Type, Print) GBMC 6701 N. Charles St. Enica 's Signati 31. Date filed (Month, Day, Year) egistra State NOV O

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ 7:30 Α Theresa 2011 Miriam Handler Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1604 Browns Road Baltimore County Essex 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours (Month, Day, Year) Country) 071-20-9738 1 □ M 2 😾 **Director** 85 Apr 26, 1926 New York Usual Residence of Decede 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a State Director 1 Yes 2 X No Baltimore Maryland Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 1604 Browns Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: WHITE 3 - Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) event, the 4 years Actress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) age 1 and 2 should be file int of Health and Mental ⊦ t: If item 27 is marked ~ ည Abraham Litz Esther Moller traumatic . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Overcrest Road Towson, Roanne Handler - DAUGHTER MD 21286 other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State injury or Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Metro Crematory INC 11-01-2011 Baltimore, Maryland Ignature of uneral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore, MD 21228 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ ME NT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atter Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? ASS 13 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate; iniury 1 Natural 5 Pending after death. Director: Af the f Accident Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day

Year.

YorkRoad

STE

02,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Month Haworth Anne 2011 P Medical October 0 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montogmery Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 228-78-4924 1 □ M 2**X** F 58 Jan. 24, 1953 Virginia 28a-f show with the Maryland 10a. State 10c. City, Town or Location Examiner must be notified at Director Prince George's New Carrollton 1 Yes 2X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6504 Jodie St. 20784 United States within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ,0 þ 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) should be filed within and Mental Hygiene. College (1-4 or 5+) the Child Care Provider Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myers Pope Marion Turner Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl tment of Health a Lawrence L. Haworth / Husband 6504 Jodie St., New Carrollton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛱 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lincoln Cemetery 11/01/2011 21. Signature of Funeral Service Lic Name and Address of Facility
app Funeral and Cremation Services 22. Name Rapp MOLBS Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition ANOXIC BRAIN INJURY (NON-TRAUMATIC) DAYS Medical resulting in death) Due to (or as a consequence of Examiner CARDIAC ARREST 12 DAYS Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Cause (Disease or injury that initiated events CORONARY ARTERY DISEASE and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS, HYPERTENSION, RENAL FAILURE, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? OBESITY 24a. Was an autopsy performed? Yes 2X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💢 No Other: ပု 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti le of certifie D56963 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 6410

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Hersker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28, Physician/ 2011 October 10:53A M Haen Hersker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🔣 M 2 🗆 F Days Hours (Month, Day, Year) 01/29/1944 Months Director 189-34-0994 <u>Pennsylvania</u> Usual Residence of Decedent show 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It is a 23a or 28a-f sho item 2.7 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at orther traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2X No MD Cecil North East 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21901 <u>103 Elk River Manor Drive</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Design Mechanical Drawing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Haen Dorothy Hersker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 State Route 93, Sugarloaf, PA 18249 Charmaine Maynard / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State 10/31/2011 Hanover, Maryland Anatomy Gifts Registry 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Funeral Serv Anatomy Gifts Registry Licensee 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Part 1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Praysician/ Sorravon disease or condition resulting in death) Medical Due to (or as consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month Day signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a Was an has performed? After this certificate completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one examiner? Inpatient 2 ER/Outpatient 3 DOA 은

Division of Vital Records, P.O. Box 68760

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 2 Accident 5 Pending Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my arising Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0060756

29d. Date signed (Month, Day, Year)

State Registrar

32. Registrar's Signature 31. Date Ned Month, Day, Year)

29b. Signature and title of certifier

2011

30. Name and address of p

DHMH 17 Rev 7/2009

s after death.

within 2 To the I

pleted cause of death (Item 23a) (Type, Print)

parko

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G921 11/22/2011 JH &7 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:10p<sup>M</sup> Carol Ann Houck October 29 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) Social Security Number If Under 1941 6. Sex Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min 12/24/1 North Carolina **Director** 239-64-4943 Usual Residence of Decedent 28a-f shov 10a. State with the Maryland or items 23a or 28a-f sho miner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Virginia Avenue, 21286 U.S.A. Apt. 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service 12 Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wilburn Salmon Ruby. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Deborah Romano / Niece Randolph Street, Arlington, VA 3346 Ν. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation, 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 10/31/2011 Hanover, Maryland Anatomy Gifts Registry 21. Signatur of Funeral Service L censee 22. Name and Address of Facility Anatomy Gifts Registry MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner covertibily list non-litious if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? detached for Month Day Year Yes 2 No. the Unknown g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy performed? Yes 2 A No death? the Hospital or Attending Physician: The hin 24 hours after death.

the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V-Pavi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8: 42 PM Wilbert R. October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death  $\stackrel{\text{}}{N}A$ 4b. City, Town, or Location of Death Examiner Baltimore Union Memorial Hospital 5. Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs, last birthday) **Funeral** 1 XXM 2 - F 214-68-4610 53 Director Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore 1X Yes 2 ☐ No MD NΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 USA 1107 Glen Eagle Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after deat Department of health and Mental Hygiene. Important if item 27 is marked other any injury or other traumary. Black, White, etc. African 1 Never Married 2 Married þ Yes 2X No 1 Yes 2XXNo Specify: If Yes, Give Specify: American 3 Widowed 4 N Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Construction Elementary/Seconday (0-12) 12th Grade Company Laborer Be 18. Mother's Name (First, Middle, Majden Surname) Geneva Walkins 17. Father's Name (First, Middle, Last) ဨ Wilbert Hall, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 4000 Loch Raven Blvd. Baltimore, MD. Geneva Douglas-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 11-05-11 Randallstown, MD King Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gilmor Street Baltimore, MD 21217 638 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 3 days Physician/ Pneumoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner uro sepsis Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Day Pregnant at time of death signed by the g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2 No 24 hours after death.

Funeral Director: After this certificate heleted filled in by the funeral director, pag. 1 Tes Yes 2 Z N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛮 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I AT 2438946 outober 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21218 Baltimore MD E. Bassem Khalil 201 University PKWY 31. Date filed (Month, Day, Year) State NOV 0 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 1:40p 2011 Medical give street and number) 4a. Facility Name (if not institution. 4b. City, Town, or Location of Death Examiner 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. 9. Birthplace (State or Foreign **Funeral** last birthday 8. Date of Birth Months 1 M 2 N Country) Director 217-18-025 Usual Residence of Deceden 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe ò 10a. Citizen of What Country? be r 23a ( Funeral OVC 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian. Black, White, etc. 'natural", or þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 ☑ No Specify. 3 ₩Widowed 4 □ Divorced Specify: Completed Year or Dates 3altimore, Marylánd 21215-00 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee funeral Home, P. A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to 6 as a consequence of Examiner Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 2 -110 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate 2 No Yes 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 5  $\square$  Pending injury 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu d title of certifier 29c. License number 29d, Date signed (Month, Day, Year) ess of berson who go eted cause of death (Item 23a) (Type, Print) 011 osler Date filed (Month, Day, Year) 32. Registrar's Signature State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #16acb Per FH G921 11/01/2011 JH

State of Maryland / Department of Health and Mental Hygiene
amend item 5 per fh g921 11-3-11 vt

Certificate of Death

Reg. No. 2 0 State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month \cx 6:00 PM tober Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Baltimore Randallstown 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** <del>- 251</del>-38-9185 Hours **Director** 1 □ M 2**XX**F Dec 16, 1941 69 Yrs. Usual Residence of Decedent or 28a-f show notified at 10c. City. Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yes XX No 10e. Street and Number o 10g. Citizen of What Country? 10f. Zip Code 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral USA 617 Baylor Rd. 21061 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XX No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3XX Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 In and Mental Hygiene.
7 Is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Packer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Shanahan Hazel Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any Karen Schwaab Daughter 617 Baylor Rd., Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2xx Cremation 3 Removal from State **Bayview Crematory** Nov 1, 2011 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li Fink Funeral Home, P.A. Gregory Fine M01148 426 Crain Hwy S., Glen Burnie, MD 21061 Part 1. Enter the disease, shock, or heart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Metastatic disease or condition resulting in death) (olon Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital 4 □ Nursing Home 5 □ Residence 6 12 Other (Speak) Heart Hospice Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signature 29d. Date signed (Month, Day, Year) D0053337 30 2011 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Ste 203 Smith Ave 31. Date filed (Month, Day, Year) State NOV 0 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast 2. Date of Death Physician/ 2011 Irene Beatrice Heinz :30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death antlehablitation 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 XXF Months Hours April 18, 1918 Director 214.14.6943 93 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified any once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Bel Air MD Harford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 621 Plumtree Rd 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceden. \_\_\_\_ Armed Forces? 4 Yes 2XX No 14. Race - American Indian Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xx No Specify: Specify: White XX Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) National Plastic Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Beatrice Graybill Charles McElroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Plumtree Rd., Bel Air, MD 21015 Serena Beckner 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 Removal from State cemetery, crematory or other place **Bayview Crematory** Oct. 31, 2011 Baltimore, MD 4 Donation 5 Other (Specify) Sign tu uneral Service (c) 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 23a. Part 1. Enter the disease, or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on enal-line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition ear Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be execute Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 menths?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Records, Division of Vital

Hospital Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying-Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

only one

308 BUS

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HUTINAG 1.38 PM 2011 Medical taken . Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death Dita (In yrs. last birthday) e of Birth onth, Day, Year) **Funeral** Number 9. Birthplace (State or Foreign 176-26-0909 77 **Director X**□ M 2 □ F 1-12-1934 PA 28a-f show the Maryland notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Adams Hanover 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 5473 Hanover Rd. 17331 USA items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 23 If Yes, Give Year or Dates. 2**X** No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry عد filed with. عا Hygiene. معد than "r (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Foreman Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Benjamin D. Hufnagel Frances A. Murphy other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Mary M. Hufnagel-wife 5473 Hanover Rd., Hanover, PA 17331 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of I Important: If its any Injury or of 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 11-2-2011 McSherrystown, PA 4 ☐ Donation 5 ☐ Other (Specify) Annunciation Cem. 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21. Signature of Funeral Service Licenses lehber III 1 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Biliany obstmetics Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examir executed Unresectable Pancreatic burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ò in the past 12 months? Month Day Year Pregnant at time of death the the 2 No Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 🗌 Yes No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 🐧 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 \( \text{Yes} \) 2 \( \text{No} \) 5 Pending injury filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shaper

31. Date filed (Month, Day, Year)

LES-UUC

Baltimora

October 25, 2011

11-07810 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Johnnie Hardy, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 17, 2011 2324 hrs Medical Examiner Johnnie Howard Hardy Jr. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 20 **Baltimore** N/A Johns Hopkins Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Hours Director Country) N.C. 218-86-2304 05/01/1964 1 X M 2 F 47 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No 28a-f show narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. MD Baltimore Co. Rosedale 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 25 Bohn Court 21237 U.S.A. 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Pages I and 2 should be filled within 72 hours after of Health and Mental Hygiene.

VI: If item 27 is marked other than "nature!"
other traumatic event. the "X". 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade unk unemployed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty J. Boykin Be Johnnie H. Hardy Sr. 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Baltimore, MD 25 Bohn Ct., Rosedale, MD 21237 Betty Culpepper(mother) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 128 Baltimore, MD on-site Crematory 4 Donation 5 Other Specify. 21. Sign ture of Funeral Service Lice 22 Name and Andress of Facility Own Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease a Hanging Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a,27,28a-f,per me,g923 1-18-12 sm **X** UNPENDED the attending physician ned for use as the burial The law requires that the death certificate be Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day 2 Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown as been signed by t should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 Other DOA 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 1 Natural subject hanged self 5 Pending 1 Yes 2 X No d in by the hours after death. fd 10-17-11 fd 10:50 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 300 East Madison st. Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide 6 Could not be within 24 hours at To the Funeral D completely filled (Specify) Found: Jail 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 18, 2011 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State

Registra

31. Date filed (Month, Day, Year

0

**OCMF** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:20 PM 26, Imogene Bane Johnston 2011 Medical October 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sen. Bob Hooper House Harford Forest Hill 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours Min **Director** 234-28-3022 1 M 2 XF 89 July 27, 1922 Marvland Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 West Ring Factory Rd. #1215 21014 United States ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ò 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Legislative Aide Political Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fulwider Bane E11a Rollins Augustus Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dianna Johnston / Niece 1515 Jefferson Davis Hwy. #222, Arlington, VA 22202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XX Ponation 5 ☐ Other (Specify) Uniformed Sers. Univ. 10/31/2011 Name and Address of Facility app Funeral and Cremation Services 933 Gist Ave. Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): JOHNSTON that initiated events Due to (or as a consequence of): resulting in death) Last -burial-Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 1 Yes 2 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed Yes 2 No or Attending Physician: The certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this o 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Within 24 hours after deau..

To the Funeral Director: After 1

-1-4-Alv filled in by the funer Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occ 29b. Signature an igned (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/24/2011 Johnny Nelson Jones 12:48 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days North Carolina 1070571936 577-76-6193 Director 75 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country er than "natural", or items 23a o Funeral 14159 Castle Blvd. apt.#301 20904 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Purchasing Agent UDC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic conce. ၉ Herbert Jones Bertha Brunner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oneita Bynum-Gibbs/Companion 14159 Castle Blvd. apt.#301 Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony memorial Park 11/1/2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Rome 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-trans and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autops, performed? 2 A No this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tyes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 🗌 No s after death | Director: the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier



State

3 🗆

Signature and title of certifier

Spurn

Carolyn

31. Date filed (Month, Day,

pozen

Forest

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Glen Road Silver Spring, MD 20910

D58461

October 24, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Bay 2011 VERNON TREVOR JONES. 1120 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan 5, 1940 **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Hours Country) **Director** 229-50-3579 1 🔀 M 2 🗆 F 71 NC show 10a. State 10h County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Prince Georges 1 Yes 2 X No Upper Marlboro 10e. Street and Number ō an "natural", or items 23a or Medical Examiner must be r 10g. Citizen of What Country? Funeral 13310 New Acadia Lane #309 20774 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates. 62-66 **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Administrator Howard University 5+ event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Burwell Jones, Sr. Mary Mead Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Young-Jones - Wife 13310 New Acadia Lane #309 Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MD Veterans Cemetery | 10-28-2011 Cheltenham, MD 21. Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ am negative disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any cause. Enter Underlying Cause (Disease or injury that initiated events Examine Director for as a consequence of and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 the as IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò meningioma 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performe death? certificate Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Tyes Other: မ After this o 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this
completely filled in by the funeral Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident (Month, Day, 5 Pendina work? Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signatyre and title of certifier DS2830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Parting #210

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ancy A. John		1- For State	ate of Maryla		artment of		Mental		2.0	11 3472
Physici Medical Exami		1. Decedent's Name (First, Middl	Agnes J			204.7		2. Date of Dea	Day Year	3. Time of Death 1155 hrs
Acaroai Exami		4a. Facility Name (if not institution 14210 Grand Pre Rd A	n, give street and num			b. City, Town, or L Silver Spring		October 2	4c. County of Montgom	Death
Funeral Director	Ī	5. Social Security Number	6. Sex 7	7. Age (In yrs. i		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi	irth(MM/DD/YYYY)	9. Birthplace (State or Foreignashington
any		213-86-5937  Usual Residence of Decedent  10a. State 10b. County	1 M 2 F	10c. City	50 Yrs.	on		07/2	5/1961	Country) D . C
	tor	MD Mont	gomery		ilver				10- 011 6144	1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	al Director	14210 Grand				20906			10g. Citizen of Wha	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Madical Examiner must be notified at once.	by Funera		1 Yes	ces? 2 No	If Ye	es, specify Cuban, Yes 2 No	Mexican, Pue specify:		White,	White
36 in 72 hours han "natu lical Exam	Completed	15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-		during mo	's Usual Occupationst of working life. I	OO NOT use	retired)	16b. Kind of Busi	
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Madica	Be Com	12 17. Father's Name (First, Middle, Werner Karl		-	Da	ycare P	3.Mother's Na	me (First, Middle,	Child Maiden Surname) n Willia	
MD 21 nd 2 should alth and Me m 27 is man	٩	19a. Informant's Name/Relationsh Patrice Baugh			8909	Sandpi	per C	t. Fort		Ind. 46804
Baltimore, permit. Pages 1 ar Department of Hee important: If ite		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Sp	ecify:	n State	crematory or oth uth Ca.	rroll C	rem 1		Winfi	
		21. Signature of Funeral Service	teller II		25	4 E. Ma	in St	. Westm	Funera inster,	MD 21157
Physician /Medical £xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. a. <b>Dehydra</b>	tion co	omplicat					Approximate Interval Between Onset and Death
	<b>J</b> e	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b. Due to (or as a control of the co							
ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a c							
D, be executed sician and unial - trans	dical	X UNPENDED	d AMENDED 2.	3a,pt.]	II,27,pe	r me,g92	3 1-9-	12 sm		
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unki	1 Live bird	nt at time of de	2 Fet	al death 3 [	Ectopic preg	gnancy	23d. Date of de Month	elivery Day Year
.O. Bc hat the deg ed by the g	by Phy	Part II. Other significant condition	ons contributing to c	death but not re		nderlying cause giv	en in Part I.	1		ute to the cause of death?
ords, P.C.	Completed b	Diabetes Mell	itus; Hypo	othyroi	ldism			1 Ye 24a. Was autor	an 24b. We	Probably 4  Unknown  are autopsy findings available or to completion of cause of
of Vital Records, P.O ig Physician: The law requires that the far this certificate has been signed by neral director, page 2 should be detected.	e Com	25. Was case referred to medical	1			26 Place o	f Death (Che	perfo 1 ✓ Yes	rmed? dea	ath? Yes 2 No
of Vita Physicia er this ce		examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 Inp	patient 2	ER/Outpatient 28b. Time of In	3 DOA O	ther Nur	sing Home 5	Residence 6	
Division C tal or Attending rs after death. ral Director: Aff	Certification:	1 Natural 5 Pendi	ng igation (Month, D	Day,Year)		1 Ye	s 2 No			
Divi		4 Homicide determ	nined (Specify)			, factory, office bui		or Town, S	State)	or Rural Route Number, City
To the How within 24 h To the Fun completely	Medical	(Check only   Certifying Ph	ysician: To the best on niner:On the basis of and manner star	examination a			leath occurre		and place, and due	to the cause(s)
		Allender	end, ME	<u> </u>	20-1	O.C.M			October 29,	(Month, Day, Year) 2011
		30. Name and address of person with Melissa Brassell, MD	Assistant Medi	ical Examir	ner 900 W.	Baltimore Str	eet, Baltin	nore, MD 2122	23	
Sta Regist	ate	31. Date filed (Month Day, Year)	2011 32. R. 9	strar's Signatu		N. I			· · · · · · · · · · · · · · · · · · ·	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34725 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 Month Physician/ 20 11 31 4:45 Kotraba Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Crofton Convalescent Center Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Director 347-20-7018 1 M 2X F 93 04 1918 03 Ohio Usual Residence of Dec show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Anne Arundel Crofton 1 Yes 2 X No Maryland ö 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a United States 21113 1212 Odenton Road, UNIT 320 ıral", or items 2 | Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Force: Black, White, etc. 1 Never Married 2 Married Yes 2 X No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give "natural" 3 ₩ Widowed 4 Divorced WHITE Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Retail Clerical nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Mitrovich Rosa Bell Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 8610 Fluttering Leaf Trail, Odenton, MD 21113 William Kotraba - SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Metro Crematory INC 4 Donation 5 Other (Specify) 11-01-2011 Baltimore, Maryland permit Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society Of Maryland Frederick Road, Baltimore Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 as the IF FFMALE: use ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ jo in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown detached g Unknown P.O. signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2/ No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Director: After injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 24 hours Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D53111 31 2011 MD address of person who completed cause of death (Item 23a) (Type, Print) , AWNAPOLIS, MD 2140/ 1-A TIDE WATER COLONY 2007

Registrar

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	epartment of Health and M	2011 2172
			Decedent's Name (First, Middle, Last)	Joi inoute of Douth	2. Date of Death 3. Time of Death
	Physicia Medic		Catherine E. Kirby		10 27 2011 10:00 P
and the same	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Marie and P	(4)		Frederick Villa	Catonsville	Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth:	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent 1 M 2 X F 104 Y	rs.	Aug 27 1907 Maryland
	/land f shored ed at	ţo	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Man 28a- notifie	Director		atonsville	1 ☐ Yes 2 ☐ <b>X</b> No
	ith th	ral	10e. Street and Number 711 Academy Road	10f. Zip Code <b>21228</b>	10g. Citizen of What Country?
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe	United States  ocify Yes or No-  14. Race - American Indian,
ဖွ	ter de or its	by F	1 ☐ Never Married 2 ☐ Married	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)  Black, White, etc.
003	ursaf tural" al Exa	ted	3	1 ☐ Yes 2X No Specify:	Specify: WHITE
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of worki	ing 16b. Kind of Business/Industry
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br	교육들	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)
ylaı	should be file and Mental ris marked c raumatic eve	P.	Herman C. Trimper	Mary A	. Spano
Maryland	1 and 2 should be if Health and Men item 27 is marke other traumatic		T I		al Route Number, City or Town, State, Zip Code)
e,	1 and 3 if Healt item 2 other				h, Baltimore, MD 21228  Date 20c. Location - City or Town, State
mo	Page 1 ment of ant: If it ury or o		1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State   cemetery	cramatany or other place)	02-2011 Ellicott CIty MD
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		21 Signature of Funeral Service Licensee		abb Funoral Home P A
<u>m</u>	P a H P B		Yatul M. Homen	301 Frederick Road	abb Funeral Home P.A. , Baltimore, MD 21228
			23a Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac o	Interval Between
	Ph sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	crosclaroses	Many years
	Examiner		Due to (or as a consequence of	):	/ /
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	):	
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c		
	te be executed iysician and he burial-transì	E E	resulting in death) Last Due to (or as a consequence of	):	
09	cate be executed physician and s the burial-transit	Physician/Medical	d		
Box 68760	ertific ding p	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		
XO	eath c atten	iciar	in the past 12 months?  1 Ves 2 No  1 Ves 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
O. B	the d by the tacher	hys	9 ☐ Unknown		
<u>o.</u>	s that gned be de	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rds	equire een si nould	eted			1 Yes 2 No 3 Probably 4 Unknown
000	has b	Completed			24a. Was an autopsy findings available prior to completion of cause of death?
m m	n: The fficate or, pag		25. Was case referred to medical	06 Pl 1 P (0)	1 Yes 2 No 1 Yes 2 No
Vita	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outs	26. Place of Death (Check	me 5 Residence 6 Other (Specify)
of	ng Phy ter thi neral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury inju	ne of 28c. Injury at	28d. Describe how injury occurred
ion	tendii leath. :or: Af the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	
Division of Vital Records, P.O.	or At after c Direct lin by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	spital nours neral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	Medical	(Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s) and manner state
	To t		29b. Signature and title of dertifier	29c. License number	29d. Date signed (Month, Day, Year)
	<b>\</b> ,		Catal W/ Mule 11.	b 123365	10 close 28, 2011
	HV		30 Name and address of person who completed cause of death (Item 23a) (Ty	Frederick Pd # 20	02, Balt 11021228
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 0 1 2011	harles	
			10014		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 200 17:28 M ee ma Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 9. Birthplace (State pr Foreign 8. Date of Birth .62 Days (Month, Day, Year) -824 1 M 2 M 58 Months Hours Director Usual Residence of Decedent 23a or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traun atic event, <u>the Medical Examiner must be notified at</u> 10d. Inside City Limits Director Maryland 1 PYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unknown Mar Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) 2,720 Gladys Lee-4807 permit. Page 1 and 2 Department of Health Important: If Item 2: any injury or other tonce. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Cremator 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician/ Onse and Death disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) s been signed by the attending physician should be detached for use as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Yes 2 No Other: 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death, To the Funeral Director: After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 - No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Practiciner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D62207 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 Linden Ave. Bultimore, MD 21201

DHMH 17 Rev 7/2009

State Registrar Mary

land General

32. Registrar's Signature

Hospita

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lichael Allen Lo	ottic	State of Maryland / Department o 1- For State Certificate o			201	34721
Physici Medical Exam		Decedent's Name (First, Middle,Last)		Date of Death     Month	Day Year	3. Time of Death 1732 hrs
viedicai Exami }	ner	Michael Allen Lottich  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month October 28	, 2011 4c. County of Death	
		9614 Basket Ring Road	Columbia		Howard	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213-23-2795 M 2 F	If Under 1 Year If Under 24Hrs Months Days Hours Mir		(MM/DD/YYYY) 9. Birt / 1985   Foreig Cou	hplace (State or n untry) MD
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ition			10d. Inside City Limits
<b>*</b>	Ŀ	MD Howard Columbia	ı			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	itry?
h the h		5807 Humblebee Rd.	21045		USA	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If \	as Decedent of Hispanic Ongin? ( S Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
· 5 E		1 Yes 2 No	Yes 2 X No specify:		Specify: Whi	.te
ours a	d by		nt's Usual Occupation (Give kind of nost of working life, DO NOT use ret		16b. Kind of Business/I	ndustry
36 in 72 h han "n lical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Music		· ·	Music	
d with	М	17. Father's Name (First, Middle, Last)		(First, Middle, Ma	aiden Surname)	
1215 be file antal H	Be	Jonathan Paul Lottich		_	Kassiday	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once	To		g Address (Street and Number or 7 Humblebee Rd			
re, rand freatt freatt free free free free free free free fr		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory or ot	sition (Name of cemetery, ther place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite njury or other tr		4 Donation 5 Other Specify: Chesapea	ake Crem.   2	011	Beltsvill	•
Balt permit Depart Impor injury		21 Signature of Funeral Service Licensee 40/585 22. N	Name and Address of Facilit CAF.	A/Steph ures Dr	en D. Loh . Balto,	rmann P.A MD 21286
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter t failure. List only one cause on each line.	the mode of dying, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Heroin Intoxication  Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	iner	if any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of):				
ited d ansit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.			<u> </u>	
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funcral Director: After this certificate has been signed by the attending physician and relay filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	☑ UNPENDED ☐ AMENDED 23a,27,28a-f,pe	er me,g921 11-14	-11 sm		
8760 ificate ng phys	2	IF FEMALE: 23b. Was decedent pregnant in the 2 Fe	etal death 3 Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year
30x 6876 death certificate e attending phy for use as the l	ပေ	past 12 months?  4 Pregnant at time of death 5 Ot	ther (Specify)		I World?	ay rea
D. Bc t the dea by the a	Physi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did toba	acco use contribute to t	he cause of death?
F, P.C ires that signed to the deta	ē		and any angle of the second se		2 No 3 Prob	
ords, w requir is been s should	Completed			24a. Was an		opsy findings available ompletion of cause of
Reco	E O			perform	ed? death?	
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)		
Physic Physic er this aral dir	٤	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of I		g Home 5 Re 28d. Describe ho	esidence 6 Other:	Scene
ion of tending Pheath.	tion	1 Natural 5 Pending (Month, Dey,Year)	1 Van 3 ₹ No	unknown	w injury occurred	
Vision Atte	ifica	2 Accident Investigation 3 Suicide 6 C Could not be 28e. Place of Injury - At home, farm, street		28f. Location (Str	eet and Number or Rur te) <b>9614 Bask</b>	al Route Number, City
Divis spital or At hours after d neral Direct filled in by	Certification:	4 Homicide determined (Specify) found at home		Columbia,	,Md.	
Division  To the Hospital or Attent within 24 hours after death To the Funcral Director: Completely filled in by the	Medical	29a. Certifler (Check only one)  2 Medical Examiner: On the basis of examination and/or investigated and manner stated.				
F 3 F 3	ĭ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
c pen		4M. U	O.C.M.E.		October 29, 2011	
0.1		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Jack Titus MD. Deputy Chief Medical Examiner 900 W. I</li> </ol>	Baltimore Street, Baltimore	MD 21223		
St	ate	31. Date filed (Month, Day, Year)				-
Regist	rar	NOV 0 1 2011 Server D. Lane				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Frank Richard LaMacchia Physician. October 29, 201 1 1 ar 11:58 Am Medical 4a. Facility Name (if not institution, give street and number) COILINGTON EDISCOPAL LITECARE City, Town, or Location of Death Mitchellville **Examiner** 4c. County of Death Prince George's 7. Age (In yrs. last birthday) ocial Security Number 051-16-4886 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) NY 1 🕱 M 2 🗆 F Months Days Hours Min. 04/07 74 922 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Pinellas 10c. City. Town or Location 10d. Inside City Limits Director Pinellas Park X Yes 2 No 10e. Street and Number 3641 10f. Zip Code 33782 10g. Citizen of What Country? 93rd Avenue Funeral should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or items 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No Na∨y
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Specify: White 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (154 pr 5+) Forein Service Officer Government or other traumatic event, Be 17. Father's Name (First, Middle, Last)
Giovanni LaMacchia 18. Mother's Name (First, Middle, Maiden Surname) မ Schmidt Emilie <sup>19a.</sup> Informant's Name/Relationship (Type, Print) Karen Hartnett / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1741 Peachtree Lane, Bowie, MD 20721 permit. Page 1 and 2 st Department of Health a Important: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State 11/01/2011 At I anti cortranatory Glen Burnie 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall isual 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ erebia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Tetal death in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day Year Pregnant at time of death signed by the a P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗖 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #228 ANNUSOBS Rd Glent Sale MA 20769 2200 1 avaKOI adei 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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arcio Lopes L	iban	State of Maryland / Department of Health  1- For State  Certificate of Death		lygiene	201	3473
Physic	an/	Kegistrar		Reg	J. No.	3. Time of Death
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		4a. Facility Name (if not institution, give street and number) 4b. City, To	wn, or Location of Deat		4c. County of Death	
		Laurel Regional Hospital Laurel			Prince George	's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under			(MM/DD/YYYY) 9. Birt	hplace (State or
Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Days Hours Mir	<sup>1</sup> 11/30/	1957 Foreig	<sub>untry)</sub> Brazil
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urs afi tural	φ	or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual O		work done	16b. Kind of Business/li	ndustry
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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiener. In the manufacture of the the manufacture of the then "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	To	19a. Informant's Name/Relationship (Type, Print)  Monika Pace Libanori / Wife   24 Padana	(Street and Number or Cam Ave., 1	Rural Route Numb St. FIOO	er, City or Town, State,	Zip Code) 06811
and 2 ealth 2		20a. Method of Disposition 20b. Place of Disposition (Name			20c. Location - City or	
Ore ges l t of H t of H		1 Burial 2 X Cremation 3 Removal from State tlantic Crematory or other place)		31/2011	Glen Burni	
timen rtmen		4 Donation 5 Other Specify:	· 1			-
Bal permi Depa Impo		21. Signature of Funeral Service Licensee Donota Marshall 22. Name and A	dress of Facility rem Box 14134,	ation Se	ryicas 2120	)3
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of	dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a, Acute Gastrointestinal Bleeding				Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				<u> </u>
	_	Sequentially list conditions, b. Ruptured Esophageal Varices				
	in	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause c Cirrhosis of Liver				
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O, the expression sician		UNPENDED AMENDED				
Box 68760, e death certificate be the attending physicied for use as the burned for use	an/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	nev	23d. Date of delivery Month Di	ay Year
x 60 h cert tendir use a	Cia	past 12 months?  4 Pregnant at time of death 5 Other (Specific		incy	I WOTH D	ay real
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Vital Records, hysician: The law require this certificate has been si al director, page 2 should b	Completed			perform		2 No
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in of ding Ph h.: After t	<u></u>	(Month, Day, Year)	c. Injury at Work?	28d. Describe ho	w injury occurred	
ivisior or Attendather death Director:	cat	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory of		28f Location /Str	eet and Number or Rur	al Poute Number City
Divisi	Certification:	3 Suicide 6 Could not be determined (Specify)	moe banding, etc.	or Town, Sta		a rodie ramber, orty
Hospi 4 hou Funer ely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tire	ne. date and place and	due to the cause(	s) and manner as state	1
Division  To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.				
E 2 E 8	Me		icense number	13	29d. Date signed (Mont	h, Day, Year)
		his win	D.C.M.E.		October 28, 2011	
h /		30. Name and address of person who completed cause of death (Item 23a)				
dV		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, MD 21	223		
St Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 0 1 2011  Assistant Medical Examiner 900 vv. Baltimore Street,  2. Registrar's Signifiure				
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amend #31 Per Dyr G921 Dedarmend in Health and Mental Hygiene

		-	For State Registrar		State o	ı ıvıaryıar		ai tiriei i tificate			and iv	lental Hy	Reg. No	00	1 1	21.	731
	Physicia	n/	1. Decedent's Name (First,	,								2. Date of De Month	ath		Year	3. Time o	of Death
100	Medic	al	Fern Darle  4a. Facility Name (if not inst									Octobe			2011	9:45	a <sup>M</sup>
	Examin	er	4a. Facility Name (if not inst			ber)		**		Location o			4c	County of Howa			
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under Months		If Under		8. Date of Bir		TIOWE	g. Birth	place (State	or Foreign
	Director		577-22-9785		M 2 🔀 F	90	Yrs.	IVIOITIIS	Days	nours	IVIIII.	(Month, Da		)	Cour <b>Jash</b> i	ington	, DC
	and show at	5	Usual Residence of Deced 10a. State 10b. C	_		10c. Gi	ty, Town or Lo	cation				<del></del>				10d. Inside (	
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	n the lagor 2		10e. Street and Number		_			10f. Zip						izen of W		,	
	orth with miss 23 must	Funeral Director	3910 Woodr			dent Ever in U.	0 110 1	Man Danad	2104		-i=2 /C==	oif. Van ar Na		nited			
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show er the Medical Examiner must be notified at	Completed by Fr	11. Marital Status 1 □ Never Married 2  3 □ Widowed 4 □ Div	Married	Armed For 1 Yes If Yes, Give Year or Da	ces? 2 <b>½</b> No		f Yes, speci			, Puerto I	cify Yes or No- Rican, etc.)			k, White,		
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ylaı	uld be file Mental <b>narked</b> c	입	John Miller							A	lber	ta McGu	ıl			· · · · · ·	
Maryland	e s s		19a. Informant's Name/Rela			hand	1	ng Address .0 <b>Wo</b> o	•			Route Number			. ,	Code) 2104	.3
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imo	Page nent ant: I Iry o		1 ☐ Burial 2 <b>X</b> Crem 4 ☐ Donation 5 ☐ 0	ation 3 🗌 R ther <i>(Specify)</i>	emoval from	Ciaic	cemetery, cren cdent C	-			11/0	1/2011	Ha	anove	er, N	<b>1</b> D	
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Se	Signature of Funeral Service Licensee 22. Name and Address of Facility Harry													
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8.	Ph_sician/ Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):											-	Interval Be Onset and	etween	
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sion	ttendi death stor: A y the f	Certificate:	2 Accident I	ould not be	280 Place	of Injury - At h	omo form str	M not footon		Yes 2 🗌		206 1 #	244	al \$1		I Davida Maria	- 6
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	To the Hosp within 24 ho To the Fune completely f	Σ	only one) 3 L Cer 29b. Signature and title of	ertifier		To the pest of	Triy kriowledge		License		e ario pia	ce, and due to		.,		Day, Year)	
	)				M,D.										ber	01	2011
	10		30. Name and address of policy of the Suling K. 5	erson who cor	mpleted caus	e of death (Iter	n 23a) (Type, F	Print)	licot	t Ci;	4, 1	nD, 2	104	2			
	Sta		31. Date filed (Month, Day,	'ear)	32. Re	egistrar's Signa	ature	-									
	Registra	ar	Klovember	3/ 20	$H \mid \mathbf{k}$	4401	0 1 00	4.4 2	Z			1. 10 1	2.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1 October Alma Lorelie Lauriente 2011 5:30 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Howard County Columbia Howard . Age (In yrs. last birthday) Social Security Number Funeral 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 M F h 1<sup>(M</sup>219/19<sup>2</sup>4 **Director** 275-20-8795 NY Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Howard Clarksville 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 6608 White Gate Road 21029 United States items death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1945—
If Yes, Give 1046 ו "natural", or item edical Examiner ו Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Divorced 4 Divorced 1946 White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Airline Reservation Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

7 is marked of
traumatic ever မှ Merton Jagger Van Cott Dorothy Marian Journeay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Michael Lauriente - husband 6608 White Gate Road Clarksville, MD nt of Health t: If item 27 v or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 Cremation 3 X Removal from State Department o Important: If any injury or Mt. Pleasant Cem. 11/03/2011 Center Moriches, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ usphagi ears Medical resulting in death) Due to Tras a consequence of): Examiner ecits Sequentially list conditions, Examine if any, leading to ministrate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) Day be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Cancer Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Systemic -UPUS ERYTHEMATOSIC 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Has pice 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6336

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- COLUMBIA

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 25 PM 201 M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F 68 235-66-6552 2 1943 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 X No Harbeson Director Sussex Delaware 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 19951 25423 Hollis Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Is marked other than Restaurant Waitress 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Adams Denzel Gallagher ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. McAlpine - HUSBAND permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 25423 Hollis Road, Harbeson, Delaware 19951 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Baltimore, Maryland 10-28-2011 5 Other (Specify) Metro Crematory INC Donation Ignature of Fulleral Service Licenses 22. Name and Address of Facili@remation Society Of Maryland INC 299 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter Immediate Cause (Final day **Physician** Due t (or as a consequence of): disease or condition resulting in death) Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 No 3 Probably 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မှ

/Medical Examiner The law requires that the death certificate be executed physician Box 68760 signed by the att Division of Vital Records, P.O. has certificate or Attending Physician: after death. Director: Aft the filled in by

with the Maryland

72 hours after

and 2 should be

and Mental

Baltimore, Maryland 21215-0036

Hospital: 1 ☑ Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 ☑No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Thedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated.

29c. License number

RE5-000

29d. Date signed (Month. Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

(OV State Registrar

e Funeral Hospital

within 24 hou

To the Fune

completely fi

Certification:

Medical

29b. Signature and title of certifier

ASHANK 31. Date filed (Month, Day, Year) NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 30 Day 8:30 PM Physician/ 2011 William McElroy, III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 8204 Evergreen Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 **X** M 2 □ F 71 Months Days Hours OCT. Pay Year 940 Baltmore. 217-38-6084 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State Director Baltimore Parkville 1 🗌 Yes 2 🏋 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a United States 21234 8204 Evergreen Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Black White etc ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 XDivorced Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) | Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) Accounting College (1-4 or 5+) Accountant Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked any injury or week. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William McElroy, Jr. Mary Eileen Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9544 Orbitan Court Parkville, MD 21234 19a. Informant's Name/Relationship (Type, Print) Mary Pat McElroy-Sister 20a. Method of Disposition
1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Evars Fringerog Total November Bel Air 1, 2011 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) EVansad Funerally Chapel & Cremation Services Signature of Funeral Service Licensee 21234 8800 Harford Rd. Parkville, MD in 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between mediate Cause (Final Coronary artengouseuse Physician/ disease or condition Due to (or as a consequence of Medical resulting in death) Examiner anter value Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by histon 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has exetnocandioverter Is mus Rh Division of Vital Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 31/11 130027693

State Registrar 6530 WA

ten Avenue Boltmone M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2:53 William Charles McCrory, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. Gity, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Hours Min. Director 219-38-2863 1**XX**M 2 □ F 68 Yrs November 3, Balt., Maryland 1942 ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XNo Maryland Baltimore Essex 10e. Street and Numbe 10g, Citizen of What Country? Funeral United States of Amer Road 21221 368 Nicholson death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2XXMarried 72 hours after Maryland 21215-0036 white 1 Yes 2XXNo Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Holabird College (1-4 or 5+) Elementary/Secondary (0-12) HVAC Technician Management Company permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) G Elizabeth McCrory William Lamont Dascher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn A. Lewandowski/daughter Essex, Maryland 21221 368 Nicholson Rd. Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Evans Funeral 1 Burial 2 Cremation 3 Removal from State November 4 ☐ Donation Ø☐ Other (Specify) 7, 2011 Forest Hill, Maryland Chapel- Bel Air 21. Signatur of Fun ral Service Lie Peaceful Alternatives Funeral and Cremation Center 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Carree . h, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings avallable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes ဨ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence eral Director: After this filled in by the funeral 7. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work?
1 ☐ Yes 2 ☐ No hours after death M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WI Towson Marki 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 30, 2011 4:40 A M Mettee Donald Argyle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 8/23/1930 MaryTand 212-28-3345
Usual Residence of Deceden Director 81 1 XM 2 🗆 F 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10b. County other traumatic event, the Medical Examiner must be notified at **Funeral Director** Sparks 1 ☐ Yes 2 Ϊ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21152 12 The Strand 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked, any injury or other trees မ Mabel Embly Argyle Golf Mettee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 The Strand Sparks, Maryland 21152 Elizabeth Wasowicz Mettee/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment Timonium, Maryland Dulaney Valley Mem. 11/2/2011 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Yes 2 No 25. Was cas eferred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After Matural 5 Pending Accident 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and the of certifier

LHTASHI

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUMAR

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29c. License number

71040

4105

29d. Date signed (Month. Dav. Year)

BACTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mitchellville Prince George's Collington Life Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 X F 93 Yrs 306-12-5461 Director Mar 14, 1918 Indiana Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Examiner must be rectified at 10a State 1 ☐ Yes 2/ No Director Mitchellville MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 10450 Lottsford Rd. #549 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√□ No Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Holiday ၉ Roy Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6411 Stratford Rd. Chevy Chase, MD 20815 John A. McCann/son Department of Health Important: If item 27 any Injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 11/02/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens 22. Name and Address of Facility 23a. Part 1. Enter the "scase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in ure. List only one cause on each line. Immediate Cause (Final **Physician** Days Tastroente disease or condition resulting in death) /Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of that the death certificate be execute sician and burial-trans Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □Yes 2 No Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ Hospital or Attending Physician: The law requires 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopey 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In 24 hours.

the Funeral Directory filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

Date filed (Month, Day, Year)

NOV 0 1 2011

122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1210

Jack.

32. Registrar's Signature

158 CertasAve Metchell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Steven 2. Date of Death 3. Time of Death Murray Ottober Da 24, Physician/ 5:30 Medical 4b. City, Town, or Location of Death Dundalk 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) Examiner 1642 Gray Haven Court . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Secial Security Number 54 **Funeral** 1 💢 M 2 🗆 F 50 Months Davs Hours Country) 1 Month 2 34, 19 60 MD **Director** Usual Residence of Decedent 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once. 10d. Inside City Limits 10c. City. Town or Location Director Baltimore 1 X Yes 2 □ No 10f. Zip Code 1 2 0 2 10g. Citizen of What County <sup>10e. Street</sup> 2011 East North Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: White 3 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Metal Fabricator (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Be 17. Father's Name (First, Middle, Last)
Walter A. 18. Mother's Name (First, Middle, Maiden Surname) a Murray ဨ 19a. Informant's Name/Relationship (Type, Print) Daneen L. Andryszak/Sister 19b, Mailing Address (Street and Number or Rival Route Number City or Town, State, Zip Code) 21222 20b. Place of Disposition (Name of At Cemetery, crematory or other place) At Cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 10/25/201 MDGlen Burnie,, 4 Donation 5 Other (Specify) 22. Name and Address of Facility dand PO BOX 1 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Deat shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ war Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) physician s the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 \sum Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 🗌 No Accident Investigation Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar N. Charles St. #4105 Bult 40200

completed gause of death (Item 23a) (Type, Print)

01

11-08052 Joan M. Mettee

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of L	Death		g. No. 20	1 3473	
Physicia I Exami		1. Decedent's Name (First, Middle,Last)  Joan Margaret Mettee		Date of Death     Month     October 27		3. Time of Death 1029 hrs	
		4a. Facility Name (if not institution, give street and number) 4b	City, Town, or Location of Dea		4c. County of Deat		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  1 M 2 F 78 Yrs.	If Under 1 Year If Under 24H Months Days Hours M	Hrs. 8. Date of Birth Min. August	0(MM/DD/YYYY) 9. Bi Forei 5,1933	thplace (State or gn <sup>puntry)</sup> Maryland	
ne Maryland or 28a-f show aoy fied at ooce,	tor	Usual Residence of Decedent  10a. State	ir			10d. Inside City Limits  1 Yes 2 No	
n the Mar 3a or 28a otified at	Director	716 Country Village Drive Apt.2B	10f. Zip Code 21014	1	10g. Citizen of What Country? USA		
penint. reges I and a should be thed whinh / 2 hours aree dean with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f sho iojury or other traumatic eveot, the Medical Examiner must be notified at occ.	by Funeral	1 Never Married 2 Married Armed Forces? If Yes 1 Yes 2 No 1 Yes	Decedent of Hispanic Origin? ( , specify Cuban, Mexican, Puerles 2 X No specify:	rto Rican, etc.)	White, etc.  Specify:	ican Indian, Black, White	
than "oatu dical Exan	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during mos	Usual Occupation (Give kind of tof working life. DO NOT use neetary		16b. Kind of Business/Industry Union		
ental Hygien irked other veot, the Me	Be	17. Father's Name (First, Middle, Last) Paul Reed	18.Mother's Nai Marie	me (First, Middle, M Silbersa	ck		
th and Me 1 27 is ma umatic e	To		ddress (Street and Number of Country Village			, Zip Code) Air, Md. 21	
nt of Heal other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory or other	place)	Date -1-2011	20c. Location - City or Baltimore		
Departme Importar iojury or			Redeemer I ne and Address of Facility Sc 05 Belair Road			e, Inc.	
sician edical miner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Right ventricular Immediate Cause (Final disease a. pacemaker placement	mode of dying, such as cardiac cardiac perfor	or respiratory arrestation dur	st, shock, or heart <b>ing</b>	Approximate Interva Between Onset and Death	
sician an	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  AMENDED 23a,pt.II,27,28	a-f,per me,g92	1 11-16-1			
the attending phy ed for use as the b	Physician/M	past 12 monutes	death 3 Ectopic preg	nancy	23d. Date of deliver Month	/ Day Year	
signed by be detach	و	Part II. Other significant conditions contributing to death but not resulting in the und Chronic obstructive pulmonary disease	. •		acco use contribute to 2 ✓ No 3 Prot		
cate has been s page 2 should	Completed	Atherosclerotic Cardiovascular Diseas		24a. Was ar autops perform 1 ✓ Yes 、2	y prior to oned? death?	topsy findings available completion of cause of es 2 No	
his certificate director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Chec		tesidence 6 Other	:	
death. ctor: After t		27. Manner of Death  1 Natural 5 Pending 2 X Accident Investigation	1 Yes 2 No	of heart pacemake	perforate r placemen	t	
hours after death uoeral Director: ly filled in by the	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, to determined (Specify) hospital		22 South	Greene st.	ral Route Number, City V Hospital Baltimore,M	
within 24  To the Fi	Medical	Check only  Check only  Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier		d at the time, date ar		e cause(s)	
		30. Name and address of person who completed sause of death (Item 23a)	O.C.M.E.		October 28, 201		
	- 1	Laron Locke MD. Assistant Medical Examiner 900 W. Balti	more Street, Baltimore,	MD 21223			
St	ate	31. Date filed (Month, Day, Year)  12011 32. Rigistrar's Signature					

11-07825 William McQuain

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam McQ∪ai	n	1- For State	tate of Maryla		partment o <i>ertificate</i> o		and I	Mental	Hygiene	Reg. No.	201	1 31.71
Physici	an/	1. Decedent's Name (First, Midd	ile,Last)						2. Date of D	eath	- ( 12 18 Maria	3. Time of Death
Medical Exami	ner	William Mc								18, 201		0914 hrs
		4a. Facility Name (if not institution Gateway Center Drive		mber)		4b. City, Tow Clarksb		cation of De	eath		County of Dea D <b>ntgDmery</b>	
Francis .		5. Social Security Number		7 Age /In vr	s. last birthday)	If Under 1		If Under 24	Hrs Is Date of			Birthplace (State or
Funeral Director		·				Months	-		Min.		Fore	eian .
		228-87-6758 Usual Residence of Decedent	1 M 2 F	11	Yrs	5.			June	30, 20	000	Country) Virginia
any		10a. State 10b. County		10c. C	ity, Town or Local	ion						10d. Inside City Limits
and show nce.	Ē	Maryland Mont	gomery	Ge	ermantow	1						1 Yes 2 X No
Aaryla 28a-f 1 at or	Director	10e. Street and Number	50			10f. Zip Co	de			10g. Citize	en of What Co	untry?
th the Marytand 23a or 28a-f she notified at once	흐	13100 Briarc1:	iff Terrac	e #806	•	208	374			Un	ited S	tates
h with	Funeral	11. Marital Status	12. Was Dece		U.S. 13. Wa	as Decedent of	of Hispar	nic Origin?	(Specify Yes or lerto Rican, etc.)	No- 1-		erican Indian, Black,
or its	臣	1 X Never Married 2 N	1 Yes	2 🗶 No					orto resourt, etc.)		M	ixed
rs afte ural",	ð	3 Widowed 4 Di	vorced If Yes, Give Year or Dates:		1 ) 16a. Deceder		No s		of work done		pecify: nd of Business	
136 ihin 72 hours a ie than "natura"	Completed	Elementary/Secondary (0-12)			during m	ost of working				IOD. KII	id of Business	or in dustry
036 thin 7 r than	힏	6		ŕ		Stud	lent			Mi	ddle S	chool
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle	, Last)		1			Mother's Na	ame (First, Middle			
2121; Muld be fil Mental F marked	B	Unknown							e McQuai			
MD 21 d 2 should I th and Mer n 27 is mar	잍	19a. Informant's Name/Relations			1				or Rural Route N			
■ alth alth alth alth alth alth alth alth		William McQua 20a. Method of Disposition	in/Uncle	1 20	b. Place of Dispos				Bellev Date			or Town, State
F 12 2 2 2 1		1 Burial 2 X Cremation		m State	crematory or ot	her place)		**	tober 23,			
Baltimc permit. Page Department ( Important:	H	4 Donation 5 Other S 21. Signature of Funeral Service		M	ontgomery	Cremato:	rium	Facility	2011	Be	<u>thesda</u>	, Maryland
Dem Depa Injur		Zan All	70	M01	498 Ro	pert A.	Pump	hrey I	uneral Ho	me, Be	thesda-(	hevy Chase, Inc 20814
Physician		23a. Part F. Enter the disease, of			ath. Do not enter t	he mode of d	ying, suc	h as cardia	c or respiratory	arrest, shock	k, or heart	Approximate Interval
xaminer		failure. List only one cause Immediate Cause (Final disease	Divist Essa	Injuries o	of the Head							Between Onset and Death
ZXAIIIIICI		or condition resulting in death)	Due to (or as a	consequence	e of):							
	اھ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	e ot).							-
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ted Insit	Examiner	events resulting in death) Last	Due to (or as a o	consequence	e of):	<u>-</u>						
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lox 6876C leath certificate a attending phys for use as the b	\$	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, or				2 🗆				Date of delive	•
Box 6876( e death certificate the attending phy ed for use as the b	Sign	past 12 months?	I , L CIVE DII	nt at time of	dooth -	tal death her <i>(Specify)</i>	3E	Ectopic pre	gnancy	"	onth	Day Year
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cords law requi has been	ple				<del> </del>					opsy	prior to	autopsy findings available completion of cause of
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Division of Vital Records, talor Attending Physician: The law requiring after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	B	25. Was case referred to medica examiner?	Hasnital:		7				ck only one)			
FVI Physic er this eral dir	의	1 Yes 2 No 27. Manner of Death	28a. Date o	patient 2	ER/Outpatient		Injury at		rsing Home 5			er: Scene
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r Atte	ig	- E	stigation Oct 18, 2		0914 hrs t home, farm, stree	et, factory, off			28f. Location	(Street and	Number or F	Rural Route Number, City
Div	Certification:		Id not be mined (Specify)						or Town Gateway Ce	State) enter Drive	and Route	121, Clarksburg, MD
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	<u>ख</u>	(0),000,000	hysician. To the best	- /	edge, death occur							
Tot comp	Med	29b. Signature and title of ceptific	and manner sta				cense nu					onth, Day, Year)
6.4		///	1 /	<i>,</i>			.C.M.E				per 19, 201	
5r	-	30. Name and addgess of person	who completed cause	of death (III	em 23a)					- 5.50	, 20	
OCME		Mary G. Ripple MD.	Deputy Chief M			W. Baltim	ore St	reet, Ba	Itimore, MD 2	21223		
St Regist		31. Date filed (Month, Cay, Year)	32. Reg	istrar's Sig	dark	1						
	_		177									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4c per np g921 11-4-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 11:10 A M Salvatore Anthony Nigido October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Min **™** M 2 □ F Director 109-20-4355 Usual Residence of Dece Sep. 28, 1925 New York 86 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland |Harford 1 Yes 2 No Bel Air Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21014 USA 141 Fairmont Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items. any injury or other traumatic event, the Medical Examiner mu. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 XYes 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Defense Contractor Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Josephine (nmn) Castrogiavanni Mario (nmn) Nigido 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coc 1208 Swindon Ct., Bel Air, Maryland 21014 Denise Fiamingo / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp | 11-1-2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland McComas Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service bice 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the g Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

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SALVATORE NIGIDO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

William E. Ne	idert	1	- For State	St	ate o	f Maryla	and / [		tment o <i>ificate o</i>			d Mer	ntal Hy		Reg. No	20	And the same of th	3474
Phys Medical Exa		1	I. Decedent's Name			eider	t III							2. Date of De Month October	Day			3. Time of Death 0830 hrs
		4	la. Facility Name (i Baltimore W								Town, or Burnie		of Death			c. County of E		
Funer Direct		4	5. Social Security N		6. Sex		7. Age (li	-	t birthday)	Mont	ler 1 Year					F	oreign	nplace (State or n intry) MD
			213-86-7 Usual Residence of	Decedent	1 <u>K</u> _M	1 2 F	140	35	own or Loca					07/1	//19	376		10d. Inside City Limits
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면 링크를 Physicia	7	1	23a. Part I. Enter th	e disease, or	cogniplic	tions that o		1121 death, D	Se Do not enter	ervio the mode	es P.	A; 1 such as o	2nd cardiac or	Ave S	W; (	Glen Bu	ırn	ie,MD 21061 Approximate Interval
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Division  To the Hospital or Attent within 24 hours after death To the Fuoeral Director:	2		4 Homicide	dete	rmined	(Specify)			ructio				200 000	Rd.	Lint	thicum	He	dge Landing ights, Md.
To the H within 24	Completely	200	(Check only 2	Medical Exa	miner:0	i: To the be in the basis nd manner:	of examin	ation and	d/or investiga	ition, in π	y opinion,	, death o	ccurred at	the time, da	te and p	and manner as place, and due	to the	e cause(s)
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		3	30. Name and address Theodore M	-				h (Item 2	23a) caminer	900 W	. Baltim	nore St	reet. Ba	altimore M	MD 21	223		
Day.	Stat	~	31. Date filed (Mont				egistrar's									_		

ORIGINAL

11-08003 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Brien Louis Ptak 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 24, 2011 Brian Louis Ptak 1621 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) c. County of Death 4b City Town or Location of Death **Baltimore County** 2706 2nd Avenue Parkville If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Maryland 216-90-9206 Months Days Hours Director November 01,1974 1 X M 2 F 36 Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Parkville Baltimore Maryland 1 Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygion. Department of Heath and Mental Hygion. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other fraumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8028 Ridgely Oak Road 21234 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 X No Yes White 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Maintenance St Joseph Church 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Louis George Ptak Jo Ann Hash 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8028 Ridgely Oak Road Parkville, Maryland 21234 Holly Rush (Companion) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 27, crematory or other place)
Evans Funeral Chapel—Bel 1 Burial 2 XCremation 3 Removal from State Forest Hill, Maryland Donation 5 Other Specify: 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road Parkville, Maryland 21234 Signature of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Visy only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease a Fatty Liver xaminer or condition resulting in death) Due to (or as a consequence of): b Chronic Alcohol Abuse Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury trial initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED 23a,-b,27,per me,g923 1-20-12 sm physician a X UNPENDED Physician/Medi Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth use as t 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ned by the atte 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) director. examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No 5 Pending death. Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 \_\_ Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 25, 2011 O.C.M.E. en come 30. Name and address of person who completed cause of death (item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month egistrar's Signature State Registrar

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 00 PM octobe 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Saint Thomas neorge More Nursing Center Birthplace (State of Foreign
 Gountry) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number Funeral 1 M 2 X F Months Davs Hours Min. (Month, Day, 31-28-146 Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 ☐ No Washington, DC Mashington 10e. Street and Number 10g. Citizen of What Country? Funeral 0012 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) eache + Be 18. Mother's Name (First, Middle, Maiden Surname) ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number Oty or Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 □ Cremation 3 □ Removal from State 5 2011 New Zion Baptist Church Cender Williamsburg 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses uneral Robert B. 605 S. Shirlington load Arlington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Penebral Infanction mouths disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Year Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Respiratory Eilune after death.

Director: After this certificate has I autopsy performed? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29100 Uctober 30 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QUEEnsBury Rd Hy 4 Houle MD 20789 4203 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 30,2011 2:30A Sarah H. Popp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Care Center Essex 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 9-20-192 1 □ M 2X F Months Days Hours Min 89 Yrs **Director** 236-24-1856 WV Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Numbe Ь 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 7522 Carson Avenue 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural" Specify: Completed 3 ₩ Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk <u>Western Electric</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Alex Hayes Ruth Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Washington Rd., William Hayes - Brother Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11-2-2011 Elkridge, MD Meadowridge Mem. 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Juneral S PA 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Į 5 Other (specify) Dav Month Year Pregnant at time of death ed by the a detached f 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Junknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2 autopsy performed? After this certificate 1 Yes 2 25. Was case referred to medica examiner? funeral director. Be 26. Place of Death (Check only one) Other: ၉ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniury 5 Pending within 24 hours after death To the Funeral Director: A Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29c. License number 29d. Date signed (Month, Day, Year) 69540 , M-D. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2123/4 6V

State Registrar Tigar

Shah

8873

words Rd Suite 204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Plaster Guy 3:154 2011 october Medical 4b. City, Town, or Location of Death
Whiteford Name (if not institution, give street and number)
Heaps Road 4c. County of Death Harford Examiner If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 5. Social Security Number 228-70-4711 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 12/11/1949 61 **Director** 1 □XM 2 □ F VA show 10a. State notified at 10c, City, Town or Location Director 10d. Inside City Limits MD Harford Whiteford 28a-f 1 Yes 2X No 10f. Zip Gode 21154 10e. Street and Number 10g. Citizen of What Country? ò ms 23a or must be r Funeral 1320 heaps Road items be filed within ...
Jental Hygiene.
arked other than "natural", or item.
"vent, the Medical Examiner m 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Maryland 21215-0036 Specify: American Indian If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Drywall Installer Construction Be 17. Father's Name (First, Middle, Last)
Samuel A. Plaster ermit. Page 1 and 2 should be filed erartment of Health and Mental H in ortant; If item 27 is marked ot ny injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) 2 Lilian M. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1320 Heaps Road, Whiteford, MD 21154 <sup>19a,</sup> Informant's Name/Relationship *(Type, Print)* Deborah Plaster / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2XXCremation 3 Removal from State Cheasapeake Crematory 11/1/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility permit. I Der artm Importa any inju 21. Signature of Juneral Service Licensee Dorota Marshall Vland Cremation Services Box 1413, Baltimore, MD 21203 W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final End-Stage Liver Disease Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? Yes 2 V No r this certificate haraketer death? To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death nours after death. neral Director: After the filled in by the funera Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \( \text{Yes} 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Funer completely fi 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

MSRAJAPAMLM.D 29d. Date signed (Month, Day, Year)

State

Registrar

Smith AV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-S-Rajapa ISE / M+O . ZF35 Smi

31. Date filed (Month, Day, Year)

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10/28/11

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last 2. Date of Death Physician/ Month Year 23:06 M me 2011 Medical 10 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memoria 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Director Usual Residence of De show 10a. State rms 23a or 28a-f short must be notified at 10b. County City, Town or Location 10d. Inside City Limits Director 1 Cres 2 No TIMORE 10f. Zip Code 10g. Citizen of What Country? Funeral items ; filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, and Mental Hygiene. is marked other than "natural", or iter raumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 70 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retire Elementary/Seconday (0-12) College (1-4 or 5+) ears Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or any Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number Route Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phylician Sepsis 1 day disease or condition resulting in death) Medical (or as a consequence of): Examiner 10day bleedin Gartro-intestinal Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown 5 Other (specify) Month Dav Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed page 2 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ ER/Outpatient 3 DOA 1 Npatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1X Natural work?
1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2438946 10/25/2011 M.D.

State Registrar

Bassem

Khalil

parkway

MD,

Baltimore

21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 E. . Registrar's Signa

Margaret	Ann	Pierpoint

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Margaret Ann Pierpoint	State of Maryland / Department of Health and Mental H
1- For State Registrar	Certificate of Death
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		Registrar Certificate of Death Reg. No.													
Physician Medical Examine	-	1. Decedent's Name (First, Middle Margaret	Pierpo	point					Oate of Death     Month Day Year     October 27, 2011			3. Time of Death 1857 hrs			
		4a. Facility Name (if not institution 213 Baylor Road	on, give street and number)				4b. City, Town, or Location of Oeath Glen Burnie					1	4c. County of Death Anne Arundel		
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last bi									lin			Foreign	
Director	L	215-18-0917	Yr	S.	10/05/1923   Country) M						untry) MD				
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits													
<b>≹</b>	اي	MD Anne Arundel Glen Burnie												1 Yes 2 No	
Aaryland 28a-f show	Director	10e. Street and Number						10f. Zip Code				g. Citizen of Wh	ntry?		
th the M		213 Baylor Road						21061			U.S.A.			Α.	
death with the Maryland or items 23s or 28s-f shomes be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?						Vas Decedent of Hispanic Origin? ( Specif Yes, specify Cuban, Mexican, Puerto Rica				14. Race White	can Indian, Black,		
			1 Yes 2 No				Yes 2 No specify:				Specify:			hite	
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0036 vithin ene. cr tha	ᇍ	10		Homemaker				Ov e (First, Middle, Maiden Surname)			Home				
15-00 filed with 1 Hygiens ad other		17. Father's Name (First, Middle, Frank	Last) Uh1ho	rn.				11		Name (F rgar		laiden Surname) Arno 1	_		
Z. 29 8 5 1	o Be	F L ATIK  19a. Informant's Name/Relations			19	b. Mailin	g Addres	s (Street		_		ber, City or Town		, Zip Code)	
Q D w d	7	Mrs. Denise Du	nker1y	/ Daug	_					Pas	adena,				
ore, MD ges I and 2 sh t of Health an : If item 27 in		20a. Method of Disposition  1 X Burial 2 Cremation	3 Pem	oval from State	20b. Place crema		sition (Na ther place				Date	20c. Location -	•	•	
Pages		4 Donation 5 Other Sa		ill Cemetery 11/				'02/2011 Brook1							
Baltimore, permit. Pages l a Department of He Important: If its injury or other to		21 Signature of Funeral Service	Licensee											Burnie, MD	
	1	23a Part I Foter the disease or	complications	that caused th	ne death. Do n							ation Se		Approximate Interval	
Physician Medical	-[	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a Head Injuries											Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death)		or as a conseq	uence of):										
	_	Sequentially list conditions,													
	틝	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.	e to (or as a consequence of):											
d d ansit	Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.													
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8760, tificate be ng physic as the bur	¥ .	IF FEMALE: 3b. Was decedent pregnant in th		f yes, outcome Live birth			etal death	3 [	Ectopic	pregnanc	CV	23d. Date of Month		/ Day Year	
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tren teath	ĕ	2 Accident   Pending   Oct 27, 2011   1852 h						1 Yes 2 No				28f. Location (Street and Number or Rural Route Number, City			
Division pital or Attendio ours after death. teral Director: A	Certification	3 Suicide 6 Could not be determined (Specify) Single Family Home  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number of or Town, State) 213 Baylor Road, Glen Burnie,													
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To th within To th comp	Medical	2 wedical Exa	and manner stated.					c. License		ac at		29d. Date sign			
	Cande Hallan						O.C.M.E.				October 28, 2011				
	ŀ	30. Name and address of person	who complete	ed cause of de	ath (Item 23a)										
7				dical Exam		W. Ba	ltimore	Street,	Baltimo	re, MD	21223				
Sta	ite	31. Date filed (Month, Day, Year)	2011	32. Registrar	s Signature	1	المعطرة	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 25y-201 Year 1:05 A Physician/ Cecilia Ouinn Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Westminster Dove House Carroll Hospice 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthdav) **Funeral** (Month, Day, Year) une 14,1926 Days Hours Min 1 🗆 M 2 🗓 F Maryland Director June 85 220-12-7492 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location Director 1 Yes 2 No Woodstock <u>Maryland</u> Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Completed by Funeral 21163 USA 2632 Melrose Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rigby Ruth William Vincent Sigwart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7642 Hennesey Ct. Glen Burnie, MD 21061 Mr. Mark Quinn/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 11 N Burial 2 Cremation 3 Removal from State 2011 Owings Mills, MD Garrison Forest Vets 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation . Signature of Funeral Service Licensee Services PA 1 2nd Ave SW Glen Burnie, MD 21061 100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Les Sequentially list conditions, Examine Due to (or as a core equence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 009 bumineru or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Sever Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months for Month Day Year Pregnant at time of death 2 No detached 9 Unknown 9 | Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has performed? death? 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital Other: DOVE 2 1 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Temer (Specify) this 27. Manner of Beath 28a. Date of injury 28b. Time of House Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No 1 Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fur Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D-0054218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Raman B. Kaneur 347 Malcry dure,

DHMH 17 Rev 7/2009

State Registrar Registrar's Signa ure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kozzel Eugene Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death resstman 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Newer Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Factor Worke Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William K0220 Nanc other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau randdough 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PROSTATE disease or condition YEAR Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 3 Month Pregnant at time of death Other (specify) Day Year 2 🗌 No ed by the a 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician; The law prior to completion of cause of death? performed 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 7 Be the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 2 100 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fr Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number person who completed cause of death (Item 23a) (Type, Print) State NOV 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month oppo 2011 Médical sedotec 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore The Johns Hopkins Hospital ge (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Aug. 13, 1964 216-76-1692 47 **Director** 1 XM 2 F Baltimore, Maryland Usual Residence of Dec 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Baltimore Sparks Maryland 1 Tes 2XXNo ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be i Funeral United States 21152 16809 Yeoho Road items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2AANo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify 3 Widowed 4XXDivorced "natural" Completed Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working er than the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Machinist Ridge Engineering Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the once, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marian Judith Stover Henry Carey Ruhl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16809 Yeoho Road Sparks, Maryland 21152 19a. Informant's Name/Relationship (Type, Print) Thomas Ruhl (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Bosley United Methodist November 02, Sparks, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22 Name and Address of Facility Evans Fureral Chapel & Chemation Services Markton 16924 York Road Monkton, Maryland 21111 Part 1. Entent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listophy one cause on each line. Approximate Interval Between Immediate Cause Onset and Death Ph\_sician/ Pneumothora disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 9 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Expired 10/24/4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $P^{\mathsf{M}}$ Margaret Mary Redmiles October 27, 10:15 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2646 Hampden Ave Baltimore 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9 Birthplace (State or Foreign **Funeral** 1 M 2 XX Days December 24, 1921 Maryland 89 **Director** 213-12-6144 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2646 Hampden Ave 21211 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🔀 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elias Mooney Margaret White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Robert William Mooney/ Nephew 500 E. Walnut Grove Road, Fawn Grove . Pennsylvania, 17321 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/01/11 Baltimore, Maryland 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licensee B631 Falls Road, Baltimore, Maryland, 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final -Ph sician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to in r as a conse sunce of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 Wo 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 Rio ပ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of De 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the cause of t Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the within 2 To the F only one) 29b. Signature and title of certifie verno D0008093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State NOV 0 1 Registrar

			Please Type or Pri					_		gible.
			For State of M	aryland		artment of H			0	011 01751
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	reatri	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia		Judith Aultman Rockwell						er 26, 2	
J.	Medic Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or	Location of Death			y of Death
	<i></i>		19114 Capehart Drive			Montgome				tgomery
	Funeral			e (In yrs. last	birthday)	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		Birthplace (State or Foreign Country)
	Director		007-28-3462 1 ☐ M 2 🖫 F Usual Residence of Decedent	89	Yrs.			February	7., 1922	New Jersey
	rland f shoved at	tor	10a. State 10b. County	10c. City, T	own or Loc					10d. Inside City Limits
	Mary 28a-	Director	Maryland Montgomery			Montgome	ry Villa	ige		1 ☐ Yes 2 🔀 No
	ith the		10.11/ Cara the seat Design			10f. Zip Code	886		ŭ	What Country? ited States
	ems arh w	Funeral	19114 Capehart Drive  1. Marital Status   12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of His	spanic Origin? (Sp	pecify Yes or No-		ce - American Indian,
9	ter de , or it amine	by F	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 🛣	No		f Yes, specify Cubar  Yes 2 🛣 No		o Rican, etc.)		ack, White, etc.
003	rurs af tural" al Exa	ted	3 ☐ Widowed 4 🛣 Divorced If Yes, Give Year or Dates.							y: White
15-	72 ho n "na Aedic	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	lent's Usual Occupa kind of work done d O NOT use retired)	ation uring most of wor	rking	16b. Kind of E	Business/Industry
212	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at		Elementary/Secondary (0-12) College (1-4 or :	5+)		Recreatio	n Direct	or	Conva	lescent Home
nd	filed all Hyg		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surnan	7 <del>0</del> )
yla	should be file n and Mental b 7 is marked o raumatic eve	욘	Merwyn Aultman					Mitchel		
Mai	2 should be filed within 72 hours after death with the Maryland this and Mental Hyglene.  27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	1	19a. Informant's Name/Relationship (Type, Print)  Phoebe Krajewski / Daugh			ng Address <i>(Street a</i> L Capehari				State, Zip Code) Llage, MD 20886
e,	ge 1 and it of Heali If item 2 or other		20a. Method of Disposition	20h Plac	e of Disno	sition (Name of		Date		- City or Town, State
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tone.		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mont	etery, cren gomer	natory or other place Y um, Inc.	9)   Octo	ober 29, 011	Bethes	da, Maryland
alti	permit. I Departir Importa any inju		21. Signature of Funeral Service Leansee	TOLEM					Bethesda	a-Chevy Chase, Inc.
<u> </u>	88 7 8			01619	75	57 Wiscor	<u>nsin Ave</u>	nue, Bet	hesda,	Maryland 20814
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final	e.			g, such as cardiad	or respiratory an	rest,	Approximate Interval Between Onset and Death
بعكرير	h sician/ Medical	l i	disease or condition resulting in death)  Myocard			tion			_	
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	e executed cian and ourial-transit	Examine	Cause (Disease or injury that initiated events c. Hyperte		200 Off:	·····				
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Box 68760	ath certificate be attending physici for use as the bu	Physician/Medical	d							
99	certifi anding use a	M/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth	of pregnanc		☐ Ectopic pregnanc			23d. D	Date of delivery
Box	death he atte	sicia	In the past 12 months?  1 ☐ Yes 2 ☑ No  4 ☐ Pregnant:			Other (specify)	у		N	Month Day Year
P.O.	<b>Physician:</b> The law requires that the dec this certificate has been signed by the <i>z</i> ral director, page 2 should be detached		9 Unknown  Part II. Other significant conditions contributing to death	out not result	ina in the u	ınderlying cause giv	en in Part I.	23e. Did t	obacco use cor	ntribute to the cause of death?
S, D	res tha signed d be d	d by	Chronic Bronchitis			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				3 Probably 4 🖫 Unknown
ord	requi been shoul	lete	Chronic Kidney Disease Sta	age 3				24a. Was		. Were autopsy findings available
3ec	he law te has l	Completed	Smoker					auto perfo 1	ormed?	prior to completion of cause of death?  1  Yes 2 No
la F	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Pi	ace of Death (Che		212110	
Z.	hysic this ce al dire	မ	1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpat			nt 3 🗆 DOA Othe	4 ☐ Nursing I	Home 5 🗵 Resi		
n of	ding F h. After i funer	ate	27. Manner of Death  1 X Natural  5 Pending  (Month, Death)		3b. Time of injury	work		28d. Describe I	now injury occu	rred
Sio	Atten r deat ector:	Certificate:			e, farm, str	eet, factory, office				ber or Rural Route Number,
Division of Vital Records,	al or safte		building, et	c. (Specify)				City or Tov	vn, State)	
_	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1  Certifying Physician: To the best of Check 2  Medical Examiner: On the basis of	examination a	nd/or inves	tigation, in my opinic	n, death occurred	at the time, date a	and place, and c	due to the cause(s) and manner stated.
	thin 2, the F	Me	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	ne best of my	knowledge	, death occurred at t	he time, date and	place, and due to	the cause(s) and	manner as stated.  med (Month, Day, Year)
	<b>5</b> ≥ <b>6</b> 8		Joel Calman	M.	D.	D203		1	_	er 27, 2011
	1		30. Name and address of person who completed cause of							
	HV		Joel Kalman, M.D. 1396 Pic	card D	rive,	Rockvil1	Le, Mary	land 208	50	
	Sta Registr		31. Date filed (Month, Day, Year)	rar's Signatu	40	ales				
	Registr	ar	MALA T CALL COLOR							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rosella Amelia Schmitt October 27, 2011 4:10P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore County Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours June 15, 1937 214-34-4922 74 **Director** 1 🗆 M 2 🔀 F Cockeysville, MD Usual Residence of Deced or 28a-f show notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director Maryland Baltimore County Edgewood 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 2402 Philadelphia Road 21040 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 Ken Specify: 3 Widowed 4 Divorced Specify: White Completed er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Production Operator 10 Assembly N/A 27 is marked other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental ပ္ George Joseph Noppenberger Alice Marie Chaffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Mrs.Deborah L.Wallace (Niece) Lutherville, MD. 21093 1023 W. Seminary Ave. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State
(Baltimnore County) 20b. Place of Disposition (Name of Date 1 XBurial 2 Cremation 3 Removal from State Dularey Valley Merocial Tuesday 4 ☐ Donation 5 ☐ Other (Specify) Nov.01,2011 Girdens Timonium, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

22. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

23. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

24. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

25. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

26. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

27. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility.

27. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility. 2325 York Road Timonium, Maryland Fort 1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ UNG CANCOR NONTHE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No for Month Day Year Pregnant at time of death the g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed 2 No 1 Yes Yes filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 1 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Date filed (Month, Day,

NOV 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 2:50 AM October <u>Thomas</u> James Spinn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 051-36-8404 Usual Residence of Decedent **Director** 1 🗶 M 2 🗌 F 64 02/22/1947 New York 28a-f show 10a, State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with items 23a 145 East High Street, Apt. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 2:50 а.ш. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural", 3 Widowed 4 X Divorced Specify Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Print Setter other traumatic event, Be Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elizabeth Shields Ann 19a. Informant's Name/Relationship (Type, Print) Department of Health at Important: If item 27 is, any injury or other traunonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Spinn / Brother 25 Appleton Acres Court, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date OCTOBER 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 10/31/2011 Anatomy Gifts Registry Hanover, Maryland 21. Signature Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending p as nse ( 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a 9 Unknown t by 1 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. THOMAS SPINN 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law certificate has performed? Yes 2 X No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X** No ျ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending iours a er death.

neral Director Aff
filled in by the fu 1 🔲 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a

To the Funeral D

completely filled

State Registrar 29b. Signature and title of

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

3 😿 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Mpnth, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23b Per Phy G921 11/01/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 31 Physician/ 201<sup>real</sup> 8:45 A Margaret Josephine Smith Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 9. Birthplac (Month, Day, Year) 9. Birthplac Country) July 27, 1907 Ohio Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Hours 1 🗆 M 2 🔀 Months |220-20-9741 104 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 M Yes 2 □ No Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ò Funeral "natural", or items 23a USA 21211 535 W. 27th St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates. 15 Decedent's Education 16b. Kind of Business Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ρ (UNK) (UNK) (UNK) (UNK) (UNK) UNK) permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 535 W. 27th Street, Baltimore, Maryland 21211 William C. Smith / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat'l Cem. 11-7-2011 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, MD 21009 22 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate / Interval Between shock, or heart fallure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ entire To Theen disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that juitated example. Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year n signed by the a ld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aneru autopsy After this certificate has completed filled in by the funeral director, page 2 performed' dementin 1 ☐ Yes 🏖 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2| Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Getülen 31, 2011 David 50 03227 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 DAVID DUNN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Satchell Physician/ 04: 53 PM 2011 Octobe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Hosbital Baltimore of if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 23 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director Battimore Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21215 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner 1 Yes 2 No
If Yes, Give
Year or Dates. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BACK Specify Completed 3 Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) wroth brunson 19b. Mailing Address (Street and Number or Rural Route Number, City or Robert Sister 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Kidge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Se de Listosee Fredhilton Pass Balto, Ms 2/2009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock for peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final intracciolaral hemorathon Ph sician/ 1 day disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** pertension Sequentially list conditions. Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed? 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဝ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Junit Kapooa MBBS October 30 , 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Mospital of KAPOOR 32. Registrar's Signature State NOV 0 1 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForState	State of I	Marylan					and M	1ental Hy		2011	21750
			Registrar  1. Decedent's Name (First, Middle,	, Last)		Cer	tificate	OT L	eatn		2. Date of De			3. Time of Death
	Physicia Medic	al	Brian P. Single								10 onth	25 <sup>Da</sup>		10:40 P M
	Examin		4a. Facility Name (if not institution, Prince George 's		)			Town, or $r=1$	Location o	of Death		4c P1	. County of Deat rince Ge	orge's
	Funeral		5. Social Security Number		Age (In yrs. la		If Under	•	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Birl	hplace (State or Foreign
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	show dat	tor	10a. State 10b. County		10c. City	, Town or Loc	ation							10d. Inside City Limits
;	e Mary r <b>28a-f</b> notifie	Director	MD Prince  10e. Street and Number	George's	La	rgo	10f. Zip	Code				10a Ci	itizen of What Co	1X Yes 2 No
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	death items	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S	3. V	Vas Deced Yes, spec	ent of His	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	e. etc.
50	s after al", or Exami	d by	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ried 1 Yes 2	No No	1	☐ Yes	2 <b>X</b> No	Specify.				Specify: Bla	ıck
9500-61212	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed		nt's Education est grade completed)		16a, Deced	kind of wor	k done d	ation Juring mos	st of work	ing	16b. k	Kind of Business	Industry
7	ithin 73 ene. <b>than</b> he Me	Com	Elementary/Secondary (0-12)	College (1-4 c 2 years	or 5+)	Gover	O NOT use	retired)	_			DH	HS	
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire X7 is marked other than "naturaly", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To	Brian P. Singl		,	T		/0: 1	Mary			ar Citu a	r Town, State, Zi	n Code)
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	101		30. Name and address of person	BU 4 4	G HV	123a) (Type, I		1 Ho	spit	al D	rive Ch	<u>ieve</u> i	rly, MD	20785
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		1	For State Registrar	State of Maryland		nt of Health ar te of Death		eg. No. 20	34760
	Physicia		1. Decedent's Name (First, Middle, La	01-00			2. Date of Deat Month	Day Year	3. Time of Death 7:57 PM
70000	Medic Examin		4a. Facility Name (if not institution, giv	, , , , , , , , , , , , , , , , , , ,	4b. Cit	y, Town, or Location of I	// Death	4c. County of Dea	
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	aryland a-f sho fied at	Director	10a. State 10b. County	Attack City,	Town or Location Himore				10d. Inside City limits 1 ☑ Yes 2 ☐ No
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	ems 23	Funeral	5420 G157	Aven ve 12. Was Decedent Ever in U.S.	13. Was Dec	21212 edent of Hispanic Origin	? (Specify Yes or No-	14. Race - Arr	USA nerican Indian,
5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Never Married 2  Married     Widowed 4  Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		ecify Cuban Mexican, F	Puerto Rican, etc.)	Black, Wh	lacK
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Maryland	should and M is ma raumat		19a. Informant's Name/Relationship	Type, Print)	19b. Mailing Addre	ess (Street and Number	or Rural Route Number,	City or Town, State, 2	Zip Code)
	ge 1 and 2 s it of Health If item 27 or other tra		Liston // Lan 20a. Method of Disposition	1 -	ace of Disposition (N	-	Date Pi	20c. Location City	or Town, State
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				o completed cause of death (Item:	23a) (Type, Print)	9c. License number \$ 0057	12 11	MA	2000
1	/		30. Name and address of person who N S Rayapars /			5 (03	Daltin	ore MU	012001
	Sta Registr	I.C	31. Date filed (Month, Day, Year) NOV 0 1 2011	32. Registrar's Signatu	parkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 27, 2011 2:30 P M Joseph Siegel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Assited Living, Bel Air Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 119-22-8890 89 1 X M 2 □ F Director 08/28/1922 Belarus Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland at Director notified 28a-f 1 Yes XXX No Harford Bel Air 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r Funeral 507 Ponderosa Drive 21014 US items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? 1 Nes 2 No WW II Black, White, etc. 0 Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. White 1 Yes 2 XXNo Specify. If Yes, Give Year or Dates Specify. "natural", Completed 3 X Widowed 4 Divorced edical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than " the Me College (1-4 or 5+) alth and Mental Hygiene.

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Evegnia Symefsky 17. Father's Name (First, Middle, Last) ပ Siegel Evegnia Joshua 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Ponserosa Drive, Bel Air, MD Roy I. Siegel Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lombone 1 Company Compa Somerset Hills Cem. 10/29/2011 Basking Ridge, NJ. of Euneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21014 610 West MacPhail Road, Bel Air, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an DEMENTIA has autopsy page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 YOther (Specify) ည 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred LIVING iniury 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director; of completely filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. UNION AVE, HAYRE DE GRACE 31. Date filed (Month, Day, Year) State

Registrar

(Check

only one) 29b. Signature and title of

NOV 0 1

045344

10/28/20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ october 28, 2011 4:48 Ρ Riley Alden Shoup Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Center Greater Baltimore Medical Towson Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ▼ M 2 □ F Months Hours PA Director 177-24-7618 01/02/1932 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director notified a 28a-f 1 Yes 2X No Anne Arundel Severna Park MD 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be r Funeral 831 Ritchie Highway Room 101 21146 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 27 is marked other than "natural", or ite traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Music Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Τ. Ralph Ruth Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Mr. Riley W. Eldridge / Cousin 1064 Plum Creek Drive Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 10/31/2011 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD ma Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, sician/ Neumonia disease or condition resulting in death) Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o ဂ 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🛎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 7/2009

State Registrar MD

completed cause of death (Item 23a) (Type, Print), Pavillion Suite 550 Towson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. ( 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10 Physician/ 2011 10:23A M Schaener Μ. Gloria . Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Linthicum 422 Forest View Road 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Min Hours 213-26-8422 Director 1 M 2XX 81 Yrs. 1/5/1930 Maryland ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a. State Director 1 ☐ Yes 2XX No Linthicum Heights MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 422 Forest View Road 21090 USA items · death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainment. the Medical Examiner Black, White, etc. Armed Force 1 Never Married XX Married 1 Yes XX No ρ 1 Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Joseph Burton Garey Mabel Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linthicum Heights, MD 21090 Forest View Road Mr. Richard Schaener / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, XX Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 11/3/2011 Elkridge, MD 4 ☐ Donatiop, 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature A Luneral Ser Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between iset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) e to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to for as a consequence of: attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn 1 Yes 2 No certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director, After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1. Natural iniurv 5 Pending 2 No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 2.

> State Registrar

DHMH 17 Rev 06-2011

completely

Medical

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Name and address of person who

determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

mpleted cause of death (Item 23a) (Type, Print)

Registrar's Sign

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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		for State Registrar	State of M	ai yiai i	•	tificate of L			leg. No. 2 1	1 21.761
Physicia Medic		Decedent's Name (First, Middle,     WILLIAM	Last)			THOMPSON		2. Date of Dear		3. Time of Death 7:10 P M
Examin		4a. Facility Name (if not institution,					Location of Death		4c. County of De	
Funeral		FOREST HILL HEA  5. Social Security Number			TER ast birthday)	If Under 1 Year	REST HILL	8. Date of Birth	HARF	UKD irthplace (State or Foreign
Director		215-24-3402 Usual Residence of Decedent	1 🔀 M 2 🗆 F		33 Yrs.	Months Days	Hours Min.	(Month, Day, OCT . 1	9 1928 N	iARYLAND
yland -f show ed at	ctor	10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2XX No
he Mar or 28a or potifi	Dire	MARYLAND HAR  10e. Street and Number	FORD CO			DARLIN 10f. Zip Code	IGTON HA		10g. Citizen of What C	
with t s 23a ust be	Funeral Director	1218 MAIN STREE	Т			210	34		U.S.A.	
death ritem iner m		11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe ın, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 Never Married 2 Marrie  3XXWidowed 4 Divorced	ed 1 🔀 Yes 2 🗌 If Yes, Give Year or Dates.		5 1	I ☐ Yes 🗽 No	Specify:		Specify: BLA	ACK
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filed v tal Hyg d othe event,	o Be	17. Father's Name (First, Middle, La	st)				18. Mother's Name	e (First, Middle, N	/laiden Sumame)	
uld be I Meni narke	ᄋ	WESLEY GILBER			1		LOUISE			
12 sho lith and 27 is i		19a. Informant's Name/Relationship George Thompson							City or Town, State, 2	
of Hea of Hea fitem		20a. Method of Disposition  1 XXSurial 2			lace of Dispo	sition (Name of natory or other place		Date	20c. Location - City of	
t. Page tment tant: I		4 Donation 5 Other (Sp	ecify)		RKLEY (	CEMETERY	11-3-			, MARYLAND
permit Depar Impor any in		21. Signature of Funeral Service Lic	ensee		W,	Name and Addres LLLIAM C 3 2 1 C PHT	ss of Facility BROWN COM T A RIVD	M FUNER	AL HOME-HA	ARFORD, P.A.
		23à. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that cause	d the deatl						Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as		Lilia	6 Z Z Z				Onset and Death
Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):					
be executed sician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consedu	ience off:					
be ey siciar buris	cal	resulting in death) Last	d.	a 001100qc	201100 017.					
requires that the death certificate is been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE:								
ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	l death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	elivery Day Year
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s that igned be deta	ρ	Part II. Other significant condition	s contributing to death b	out not res	ulting in the u	nderlying cause giv	ven in Part I.			to the cause of death?
require	eted							1 ⊔ Y 24a. Was a		Probably 4 Unknown
ne law e has l age 2 s	Completed							autop: perfor	prior to	completion of cause of
ian: Th	Be C	25. Was case referred to medical examiner?				26. Pl	ace of Death (Check	1  Yes	2 No 1 L Y	es 2 LSANO
Physic this ce al dire	ပ္	1 Yes 2 No	Hospital:  1  Inpati  28a. Date of inju		ER/Outpatier		4 Nursing Ho		ence 6 Other (Spe	ecify)
tth. : After e funer	cate	1 Natural 5 Pending 2 Accident Investiga	(Month, Da		injury	work	y at :? Yes 2 □ No	28d. Describe ho	w injury occurred	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Certificate:	3 Suicide 6 Could not 4 Homicide determine	ot be 280 Place of Init			eet, factory, office		28f. Location (St City or Towr	reet and Number or R n, State)	ural Route Number,
ospital hours a neral C			hysician: To the best of							
the Ho hin 24 the Fu nplete	Medica	only one) 3 Certifying i	aminer: On the basis of e lurse Practioner: To the			death occurred at th	e time, date and plac	e, and due to the	cause(s) and manner a	
Not with Cor.		29b. Signature and title of certifier	3			29c. License	number	2	29d. Date signed (Mor	
· \\.		30. Name and address of person w	no completed cause of c	leath (Item	23a) (Type, P		(5)		Tent	21, 2011
BV. 1		DAVID DUNN	615 W. MAC				AIR, MD.	21014		
Stat		31. Date filed (Month, Day, Year)	2011 32. Fegistr	ar's Signat	ture	0.4.1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 – For**State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31, 20 TT 4:45 A Earl Gene Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Gilchrist Hospice of Howard County Columbia 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 ₹ M 2 □ F Days Jan 22 ay, 1943 TN 408-66-5494 68 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 😾 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 8551 Autumn Harvest 21043 United States items filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 1961-81 "natural", Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. United States Postal life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mail Carrier Service traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Earl Mallard Taylor Jene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 4025 Fragile Sail Way Ellicott City, MD 21042 Michael George Taylor/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗆 Cremation 3 🔀 Removal from State cemetery, crematory or other place) Memphis National Ceme 11/04/2011 Memphis, TN 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Sign were of Funeral Service Lice 4112 Old Columbia Pike Ellicott City, MD 21043 Manuta 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ C ears disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P,O, Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Yes After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕏 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 DNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury **Natural** 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu ☐ Acciden ☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) မ D006063L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar BINDU . JOSE

NOV 0 1 201

31. Date filed (Month, Day, Year)

COLUMBIA

6336 CEDARL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Robert Neal Vaught Sr. 2011 0040 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth 9. Birthplace (State Aug. 30, 1940 Mary Land . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 1. M 2 □ F Age (In yrs. last birthday) Hours Director 219-34-2523 71 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 101 Pusey St. 21078 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Concrete Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Blaine Robert Vaught Nellie Helena Gaulghtney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pusey St., Havre de Grace, MD 21078 <u>Jeane M. Vaught</u> / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp | 11-01-2011 | Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death .₽π<del>ysicia</del>π/ INEUMONIA disease or condition resulting in death) Weel Medical Due to (or as a consequence of): **Examiner** CANCER Sequentially list conditions, Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed VAUGA Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 After this certificate funeral director, pag 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \( \text{Yes} \) 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 5 Pending 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a, Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) HAURE de GRACE, MOZIOTS hs man 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30,2011 Anthony Joseph Vontran Sr. 5:10 a<sup>M</sup> October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Essex Riverview Nursing Home If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days Min (Month, Day, Year) Months 212-32-7323 Director 1**X** M 2 □ F 75 Maryland April 3,1936 28a-f shov 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director notified Md. Baltimore Rosedale 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be USA 23a Funeral 21237 1521 Chivalry Court items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. o þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: "natural" Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sparrows Point Country Club the Security Guard 10 years of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Joseph Vontran Martha Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1521 Chivalry Court, Rosedale Md. 21237 Marilyn Vontran Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of November cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dundalk, Maryland Oak Lawn Cemetery 2011 2, 4 Donation 5 Other (Specify) 2. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. Signature of Fundal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the courth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine thany teacing to immedicause. Enter Underlying Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day , the a 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

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only one

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1 2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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M.D e and address of person who completed cause of death (Item 23a) (Type, Print)

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Prenne

29d. Date signed (Month, Day, Year) 301

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Michael Weiss, Jr October 29, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 11522 Glen Arm Road Glen Arm 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 28, 1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 214-12-2366 Maryland **Director** 1 🏝 M 2 🗆 F 91 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Glen Arm 1 Yes 2 XNo 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11522 Glen Arm Road 21057 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc a 1 and 2 should be filed within 72 hours after d of Health and Mertal Hygiene. If item 27 is marked other than "natural", or i if rether traumatic event, the Medical Examin r other traumatic event, the Medical Examin þ 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) Baltimore City College (1-4 or 5+) Engineer 12 Housing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Michael Weiss, Sr Louise Sommerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Weiss-spouse 11522 Glen Arm Road-Glen Arm, Maryland 21057 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. John's Catholic Church Cemetery permit. Page 1 Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov.2,2011 Hydes,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 · Mª Fada 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ACUTE MYECARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner STONOSIS ADRICA Seque tially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): BIGUSPID ADRTIC requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) physician ar resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 9 Unknown 2 🗌 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown ALZHEIMER'S DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has certificate l 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ N within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 2 Medical Examiner. On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) Det but 31, 2011 Screna R Nolad mo 00025010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
\$531 SATYE HILL RO #100 BACTIONE NO 21254 Nolan

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Sign ture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 wood 12:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. | 15, 1918 525 Secial Security Number 525 - 20 - 5165 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Director 92 Yrs New Mexico Usual Residence of Decedent 28a-f show 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Tes 2 No Catonsville 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a ( Funeral 719 Maiden Choice Lane HRT39 21228 USA items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? ö þ 1 Never Married 2 3 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Architect Architecture is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chester Arthur Wood Gladdice Leona Halcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Wood Wife 1 and 2 s if Health a item 27 i 719 Maiden Choice Lane HRT39; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/1/2011 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 630 Edmondson Avenue: Catonsville. MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) \_\_\_\_ Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Congestive heart Failure 1 Yes 2 No 3 Probably 4 Monknown Arrial F. brilla tion 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural work? 1 ☐ Yes 2 ☐ No 5 Pending after death. 2 Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed The deficiency in statement to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 13×11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hoice Lune, Cotonsville, mp 21228 711 Maiden mD

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State Registrar 31. Date filed (Month, Day, Year)

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Records,

**Division of Vital** 

Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland Department of Health and Mental Hydiene in Certificate of Death

Reg. No. State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month I O Physician/ Weaver Ronetta Irene Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** R altimot Sinai If Unde If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Months Hours 1 □ M 2 🗓 F **Director** 215-60-4739 21 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Yes 2 No Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21215 U.S.A. 5531 Nome Ave Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 ▼No Specify: Black If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 🌠 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore, Maryland 21215-12th grade College (1-4 or 5+) <u>Department of Defense</u> Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Virginia C. Whalen <u>Samuel Barbee</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1232 East North Ave, Baltimore, Md 21202 Skip Barbee-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/29/2011 Woodlawn Woodlawn, 22. Name and Address of Facility
March F/H West
4300 Wabash Av of Funeral Service Licenses 21. Signatur Baltimore. Md Ave, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ complian c disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the atte d be detached for Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 Mnknown 1 Yes Completed should been ( 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed' 2XX No 1 🗌 Yes 2KYes 25. Was case referred to medical 26. Place of Death (Check only one) å examiner? Hospital Other: 1 🗌 Yes 2 V No ၉ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred completed filled in by the funeral Certificate: 28c. Injury at injury work? 5 Pending Natural Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of D00694 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 2401 West Belvedere Ave. Baltimore, MD 21215 James Petit State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death THA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Baltimore Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 218-36-0678 Months Hours Min (Month, Day, Year) 73 1 □ M 2 🕱 F Yrs. 7 1938 6 S. C. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Randallstown 1 Yes 2 X No 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 21205 533 N. LakewoodAve. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Black 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) N/A College (1-4 or 5+) Elementary/Secondary (0-12) N/A Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maggie Brown George W. Sawyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2746 Albermarle Pl. Waldorf, MD 20601Helen M. Hargrove-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State King Memorial Pk. 11/5/2011 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. 21202 Ave. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of):

Physician/ Medical **Examiner** Examine

Physician/

Medical

Director

Funeral

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Completed

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Examiner

**Funeral** 

**Director** 

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ıral", or items 23a o Examiner must be

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural", or items; any ipiury or other traumatic event, the Medical Examiner musones.

Baltimore, Maryland 21215-0036

with the Maryland

attending physician and I for use as the burial-transit

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician;

dical		d				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1  Live Birth 2 Fet 4  Pregnant at time of 9  Unknown	al death 3 🔲 Ectop	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Completed by Pi	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	ng cause given in Part I.	1  Yes  24a. Was an autopsy performed;	
To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3 🗌	26. Place of Death (Che	1 ☐ Yes 2 🔏 eck only one)  Home 5 ☐ Residence	bacaro
Certificate: 1	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?  1 Yes 2 No	28d. Describe how inj	
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Medical	(Check 2 \( \sum \) Medical Exam	sician: To the best of my know iner: On the basis of examinations se Practitioner: To the best of	n and/or investigation,	in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and manner stat

DHMH 17 Rev 06-2011

State Registrar 29b. Signature and title of certi

Name and address of person

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 27 2011 White 9:16 Ρ Antione Robert . Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min 2 16 73 37 MD Director 213-15-7278 Usual Residence of Decedent 28a-f show 10a, State 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c City Town or Location Director 1 X Yes 2 □ No Dover PA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17315 U.S.A. Funeral 4109 Strawbridge Ct. Apt 17315 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married ğ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exar 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County should be filed within 72 and Mental Hygiene. 12th grade (0-12) 6 yrs Teacher Public School permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Regina James Robert White Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Evesham Ave, Baltimore, Md 21212 Regina White-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Arbutus Memorial 11/4/2011 Arbutus, 21. Signature of Funeral Service Licenses March For of West 21215 Baltimore, 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fature. List only one cause on each line. Approximate Interval Betweer Ansel and Death Immediate Cause (Final Physician/ pu/monary nassive disease or condition Medical resulting in death) **Examiner** Sequentially list or clittors, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events acute renal failure tailure. Exami , respiratory and resulting in death) Last physician at the burial-Physician/Medical neumonia ionella Division of Vital Records, P.O. Box 68760 attending E FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death
Unknown 2 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed dependent diabeter mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA nours after death.
neral Director: After this if illed in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral E

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi D2711 10 meers

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month

30. Name and address of person who completed gause of death (Item 23a) (Type, Print) OWISCIA

N. Charles St Baltimore MD 21204

Warren, Ralph A. 10/27/11 2208 PM

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in	Medic Examin	_	4a. Facility Name (if	not institution	, give stree	et and numbe	r)		4b. City,	Town, or	Location o	of Death			c. County			
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	Funeral		5. Social Security N		6. Sex		Age (In yrs. Ia		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		Count	ry)	or Foreign
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	land show dat	φ	10a. State	10b. County				, Town or Loc								1		City Limits
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man	Physician/		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition	art failure. List ( (Final	only one c	tions that cau ause on each Pulmon	sed the deatl line.	n. Do not ente	er the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approxim Interval B Onset and	nate etween
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P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c		th 2 ☐ Feta nt at time of o	al death 3	Ectopic p Other (sp		y 					te of delive	ery Day	Year
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Division of Vital Records,	ne faw requ e has beer age 2 shou	omplete	Pulmonar	у Нурез	rtens	ion							24a. Was auto peri 1 \( \subseteq \text{ Yes}	opsy formed?	, .	Were auto prior to co death? 1  Yes	mpletion o	s available f cause of
<u>=</u>	an; Th	Be C	25. Was case refer	red to medical						26. Pla	ace of Dea	ath (Check		۷۸	140	1 🗀 163	2 110	
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1	ithin the other	Σ	only one) 29b. Signature and	3 Certifying		ractitioner: T	o the best of r	ny knowledge			he time, da number	ate and pla	ce, and due to		Date signe			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) October Physician/ A M 2011 1:55 Cleve Barrington Wilmot Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Linthicum The Tate Chesapeake Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days Months Hours Director 216-98-7011 1 🏻 M 2 🗆 F 61 1-17-1950 Jamaica Usual Residence of Deced or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director 1 Yes 2 X No Severn Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number ms 23a or must be I Funeral United States 21144 1735 Carriage Lamp Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ı "natural", or item edical Examiner n Armed Forces? Black, White, etc 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed African American Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Satellite Specialist NASA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Minna Isadora Davis Vernon Wilmot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1735 Carriage Lamp Court Severn, Maryland 21144 Paulette Joy Wilmot / Wife 27 Department of Health Important; If item 27 any injury or other th once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 10-30-2011 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u> Arundel Crematory :</u> 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Funeral Servic Joseph Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ east disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death
9 Unknown 2 No the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 Jas certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be USPICE Other: 4 Nursing Home 5 Residence 2 No couse 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. Natural work? 1 ☐ Yes 2 ☐ No 5 Pending To the Funeral Director, A completely filled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 28, 2011 D39505 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yudhish Markan 305 Hospital to Glan Burnie, MD.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 11:00 P M 2011 October WASHINGTON WILBUR RAY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince Georges Brandywine 11725 Redwood Dr. . Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Nov. 27 Months Days Hours 1 XM 2 | F Director 577-42-0524 78 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show iral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b County Director 1 Yes 2 K No Brandywine Prince Georges 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20613 11725 Redwood Dr. East 12. Was Decedent Ever in U.S. Armed Forces?

1 

X Yes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed ed other than "natur event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
U.S. Marshall's 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Brent John Washington traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6048 Netherton Street Centreville, VA 20120 Regina D. Washington/Daughter Important: If item any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery | 11/2/2011 Cheltenham, MD 21. Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death いんれいいん Immediate Cause (Final inte Priysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Dusito (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death the g Unknown P.O. E ed by s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No ☐ Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation
6 Could not be M 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifie 29c. License numbe 10-28-11

State Registrar

DHMH 17 Rev 7/2009

St NW # 3300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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F 32. Registrar's Signature

LIPPHAN MO

31. Date filed (Month, Day, Year)

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WASHINGTON

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			<ul><li>State</li><li>Registrar</li></ul>	/ <del>/</del>	1 4)		_	Cer	tificate of L	Death	1	Reg. No. 2		34776
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-	Examir	er	4a. Facility Name (if 3420 Chest			number)			4b. City, Town, o  Baltimo	r Location of Death		4c. Count	y of Death	
	Funeral Director		5. Social Security Nu 213-37-		6. Sex 1 ☐ M 2 💢	7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth	1	9. Birthp Count	olace (State or Foreign triphillipines
	iryland a-f show ied at	ctor	Usual Residence of 10a. State	10b. County	J/A		10c. City,	Town or Loc		timore			1	0d. Inside City Limits  XX Yes 2 □ No
	with the Ma 23a or 28a st be notii	Funeral Director	10e. Street and Num 3420		•	ue 1			10f. Zip Code	211		10g. Citizen of	What Coun	
9036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	þ	11. Marital Status  1  Never Marri 3  Widowed		ied 1 🗆 Ye	Forces?		11	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	etc.
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygtene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exagonce.	Completed	(Spec	cify only highe	t's Education of grade complet College	ed) e (1-4 or 5-	+)	(Give k	ent's Usual Occup ind of work done of NOT use retired) Grocer	during most of work	ing	16b. Kind of E	Business Inc etail	dustry
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	and 2 shoul Health and I tem 27 is ma other traums			. Wilm	ip (Type, Print) er / Spo	use				and Number or Run nue, Balt	al Route Number IMOre, M	10 <sup>ty</sup> 2127	State, Zip C	Code)
Baltimore,	permit. Page 1 and Department of Hea Important: If item any Injury or other		4 Donation	Cremation 5  Other (S			Ches	apeak	sition (Name of patory or other place PEMATO		9/2011	Belts	ville	, MD
Bal	permit Depar Impor any In		21. Signature of Fun	eral Service Li	censedorot	a Ma	rshal	22.	Name and Address	stor Facility Cr Sox 1413	ematio	n Serv imore	i MBs	21203
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09		dical Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or it that initiated events resulting in death) L	lying injury	C		conseque	nee ofj.				hold		28 mini
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours death.  Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transi		IF FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2 9  Unknown	onths?	4 🔲 Pr	ve Birth 2		death 3 🗌	Ectopic pregnanc Other (specify)	ey			ate of delive	ery Day Year
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Division of Vital Records,	sician: The law require certificate has been si irector, page 2 should	Completed by									24a. Was a autops perfori 1 Yes	med?	prior to con death?	osy findings available inpletion of cause of
ital	Physician; Trips certificar ral director, p	Be	25. Was case referred examiner? 1 \(\sum \) Yes 2		Hospital:				LO41	ace of Death (Chec	,			
of V	ter this	te: To	27. Manner of Death	5 Pending	28a. Da		/ 2	R/Outpatient 8b. Time of injury	28c. Injury	4 □ Nursing Ho	ome 5 Reside 28d. Describe ho			
vision	or Attendir ifter death. <b>Virector:</b> Af in by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation of the determination of the determina	ot be 28e. Pla		y - At hom			Yes 2 No	28f. Location (St. City or Town		per or Rural	Route Number,
۵	to the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	Medical (	(Check 2	_ Medical Ex	aminer: On the b	pasis of exa	amination a	and/or investi	gation, in my opinio	, date and place, ar on, death occurred a	the time, date an	d place, and du	e to the cau	se(s) and manner stated.
	To the To the Complet		29b. Signature and ti		m H	L	109 10		29c. License	number	2	9d. Date signe	ed (Month, E	Day, Year)
	0√		30. Name and address	M.	Hahh			3a) (Type, Pr	int) Rac	ven B	ud B	eltin	ione,	2011 m221239
1 18	Stat Registra		31. Date filed (Month,	Day, Year)	2011 %	Registrar	's Signatur	Mar	Red					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 31 2011 ANDORA 0 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MARIS TELLA BAUTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 217-24-5851 Director 1 □ M 2 XF 80 or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland **Funeral Director** 1X Yes 2 ☐ No BATIMORE MD 10g. Citizen of What Country? 10e Street and Number 0 items 23a or ner must be n CECIL AVENUE USA 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedor... Armed Forces? 1 ☐ Yes 2 🔀 No "natural", or itel edical Examiner Black, White, etc Completed by 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 📈No Specify: If Yes, Give Year or Dates Specify: BLACK 3 🗌 Widowed 4 🗎 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me ife. DO NOT use retired, HEALTHCARE Elementary/Secondary (0-12) College (1-4 or 5+) HSSISTANT D Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) 2 DWAYNE JOHNSON Addison Page 1 and 2 should be ment of Health and Ment CONARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CECIL AVE. BANTO, MO. 21218 Important: If item 27 is any injury or other trau once, KAYMOND L. WILSON (SPOUSE 3altimore, CTOBER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State BACTIMORE, MD GARRISON FOREST 4 Donation 5 Other (Specify) VAUGHN EREENE FUNERALSONS Signature of Funeral Service Licer 22. Name and Address of Facility 4905 ROAD. BALTIMORE, MD YORK 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day been signed by the atte should be detached for Month Year PANDORA WILSON 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by **√** No To the Hospital or Attending Physician: The law requires 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy perform death? Yes 2 X No 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE ဂ္ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title,

**JACKIE** 

JONES,

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ Clara M. Wille October 30 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Emeritus Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Months Hours 212-10-0466 1 □ M 2 🗓 F 101 **Director** 8-13-1910 Maryland 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland notified at Director 1X Yes 2 ☐ No Baltimore Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or r must be r ò Funeral USA 21212 6451 N. Charles Street Apt.305 items 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc. þ 1 Never Married 2 Married Wh⊥te Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🔀 No Specify If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) C & P Telephone Supervisor 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Graczkowski Theodore Biernert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 High Ridge Drive Westminster, Md. 21157 19a. Informant's Name/Relationship (Type, Print) Nephew Allan G. Skewers 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 KBurial 2 Cremation 3 Removal from State 11-4-2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Schimunek Funeralliome. Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Debilot Ph, sician/ YUNY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death been signed by the a should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed: 2 🗌 No After this certificate I 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be HSSISTED LIVING examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 W Other (Spec 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: After Properties of the function by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the F 3 [ only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 07 31 2011 ocrosen 30. Name and  $^{t}$ address of person who completed cause of death (Item 23a) (Type, Print) NNO harles N 1701 31. Date filed (Month, Day, Year) State 0 VOM Registrar

			Please	Type or Print i						_	
		-	For State Registrar	State of Maryl		epartme Certifica				glene Reg. No. 20	34779
	Physicia Medic		1. Decedent's Name (First, Middle, La.	Salfer )					2. Date of Dea Month	Day 28 201	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give Bon Secons Ho				It m	Location of Death	ty)	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. S 214-38-3987		rs. last birthe Y	day) If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan . 2	9. Bir 5,1941	thplace (State or Foreign nuntry) N.C.
	laryland 3a-f show ified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD	10c	. City, Town Ba	or Location	re				10d. Inside City Limits 1 <sup>™</sup> Yes 2 □ No
	with the N s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 1401 Edmondso	n Ave. Apt	.307		ip Code 2122	3		10g. Citizen of What C	ountry?
920	s after death al", or item: Examiner m	ह	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.	ı U.S.	If Yes, sp	ecify Cuba	spanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4 or 5+)	7	ife. DO NOT u	ork done d	ation during most of work	ing	16b. Kind of Business Social S Adm.	
yland 2	ld be filed w Mental Hygi arked othe atic event, i	l o	17. Father's Name (First, Middle, Last) Wallace Berry	BA Degree -		lerk		Letha	White	Maiden Surname)	
e, Mar	and 2 shou Health and em 27 is m ther traum		19a. Informant's Name/Relationship ( Leona Walker  20a. Method of Disposition	(Daughter)	14		mond	son Ave	. Apt.	7, City or Town, State, Z 307 Balto 20c. Location - City o	,Md. 21223
ltimor	it. Page 1 artment of hartment. If its njury or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery	, crematory or Mount	cther place Cre	matpry	7,2011	Balto,Md	•
Ba	permi Depar Impol any ir			×	>_					eral Home	21213
•	hysician/ Medical	8 8	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a con	dial i	nfacet	ion			est,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	ecquenes o	Dr.	asculo	ir diseas	<u>e</u>		
	oe executed ician and burial-transit	al Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. <u>diabete</u> . Due to (or as a con					_		
8760	tificate by physical physical physical as the t	Medic	IF FEMALE:	d	===					T =	
. Box 68760	or Attending Physician: The law requires that the death certificate be after death.  Jinctor. After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death	3		ру		23d. Date of d Month	elivery Day Year
ls, P.O.	uires that the signed by ald be detact	þ	Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlying	g cause gi	ven in Part I.		obacco use contribute t	o the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law rec ate has bee page 2 sho	Completed							24a. Was autoj perfo 1 🗆 Yes	osy prior to death?	utopsy findings available completion of cause of as 2 No
ital	sician: certific rector,	Be	25. Was case referred to medical examiner?  1 Ves 2 No	Hospital:			Oth	ace of Death (Chec			16.1
n of V	iding Phys th. After this funeral di	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 28a. Date of injury (Month, Day, Yea	28b. Ti		28c. Injur worl	y at		dence 6 Other (Spe	сіту)
Divisio	al or Atter s after dea Il Director ed in by the	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injuny -		m, street, facto	ory, office		28f. Location (S City or Tov	Street and Number or R vn, State)	ural Route Number,
_	To the Hospital or Attending Physician: The law within 24 bours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nu	ysician: To the best of my k niner: On the basis of exami rse Practioner: To the best	nation and/or	investigation, i	n my opini curred at th	on, death occurred a le time, date and pla	at the time, date a	ind place, and due to the e cause(s) and manner a	e cause(s) and manner stated. s stated.
	Nith Con		29b. Signature and title of certifier  Multiput	W MD			9c. Licens	250		29d. Date signed (Mon	
	Ve		30. Name and address of person who Kathon Stah	completed cause of death	(Item 23a) (T	gpe, Print)	<i>ب</i> و 2	+ , Balt	more M	0 21223	
y.	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 1 2011	32. Registrar's S	Signature	w		7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9.40 XIBBE Charles Gene Workman Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death WASHINGTON MEDICAL CE ANHE KALTIMUSEE BURNIE NTF2 CHEN Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Month, Day, Y 4/1928 1**XX**M 2 □ F Days Min. 400-30-4118 83 Yrs. **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location notified at 10d. Inside City Limits Director MD Glen Burnie 1 ☐ Yes 2XX No Anne Arundel 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral USA 1129 Armistead Street 21061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married XX Married Morkmand, CHARLES G Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Purchasing Agent Masonry Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pleasant Calvin Workman Omie Mae Crass injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Daughter XORKMAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Mrs. Donna Leigh Hoffman / 116 Glenlea Drive Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 10/29/2011 5 Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 21. Signature of Juneral Se 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 10122 art 1. Enter the diseas, or coord lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ M/ETASTATIC MON HODGICINS disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Ded the Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed After this certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Fractionars to the basis of my line wedge, death occurred at the time, date and place, and due to the cause(s) and meaning as about. (Check only one 29b. Signature and 29c. License number 29d. Date signed (Month. Day, Year) d cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

30.-Name and address of person who complete

ONABAI

NOV

31 Date filed (Month

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32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 8.30 PM RANDOLDH Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health & Rehab Ellicott City Howard 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 05/22/1916 Min. 1 🕅 M 2 🗆 F Months Hours Country) 95 Director 213-12-0956 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits the Maryland notified at 10c. City, Town or Location Director 28a-f 1 Yes 2 X No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ntal Hygiene. 3d other than "natural", or items 23a or event, the Medical Examiner must be r Funeral 4906 Rollingtop Road 21043 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: 3 XWidowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Screen Machine Shop Repairman marked other Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Hannah Beahm Andrew Jackson Young other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a 4906 Rollingtop Road Ellicott City, MD Betty L. Ramey - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/03/2011 Marriottsville, MD Crest Lawn Mem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hnne Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir The law requires that the death certificate be executed as the burial-transi physician and that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Other (specify) Pregnant at time of death the detached g Unknown 9 I Inknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

10

State Registrar Back Diver MCK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamesh \_

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abapalm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gordon Thomas Bedford Physician/ October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex 1 ★M 2 ☐ F 7. Age (In vrs. last birthday) Days England Months Hours 2/16/1913 98 370-03-2509 Director "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10h County 10d. Inside City Limits 10a, State 10c, City, Town or Location filed within 72 hours after death with the Maryland Director Annapolis Anne Arundel Maryland 1 🗓 Yes 2 🗌 No 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral P.O. Box 3498 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Engineering Metallurgical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas S. Bedford Mary MacGillivray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 York Lane, Annapolis, MD 21403 Marilyn Clark - POA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of H 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Greenlawn Mem Garden's 10/21/11 Chesapeake, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 1. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physiciana disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the bunial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for use as the hinal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' 1 Yes 2 No Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? 2i No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending death. 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the only one 29b. Signature License numbe

State

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1 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/117 2011 Year Herbert J. Butler 1030 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Charlestown Renaissance Gardens Catonsville If Under 1 Year | If Under 24 Hrs . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X X M 2 D F Min Hours 91 Country) 013-18-3340 1477/1919 Director Yrs Vermont Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Baltimore Catonsville 1 Yes XX No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 719 Maiden Choice Lane 21228 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. event, the Medical Examiner Armed Forces? Black, White, etc ō ₽ 1 Never Married 2x Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2XXNo Specify. White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any highry or other traumatic event, the Mone. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) RN Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Butler Ina Stearns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Lillian Butler Wife 719 Maiden Choice Lane Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) 10/16/2011 Atlantic Crematory Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 7 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Stag Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 - No Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending Accident
Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar (Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

709

32. Regis ar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R165717

Maiden Choice Lane Catonsville mp 21228

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

			1 - For State Registrar	tate of Maryland	Certifica			-	Reg. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	\	."			2. Date of De Month	ath Day	Year	3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give street	and number)	4b. Ci	tv. Town, or	Location of Death	12		2 11 ounty of Death	8:45 PM
-11	/		St Thomas More	- Worsing He	sme H	youth	sulle	an		mre	heorges
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In y s) last t	birthday) If Und Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birl 07/01/	:h	9. Birth	place (State or Foreign often) eburg, S.C.
	nd thow at	្ក	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			·			10d. Inside City Limits
	Maryla 28a-f s ptified	rect	D.C.	Wa	shington	l					1 ▼ Yes 2 □ No
	with the 23a or 3	Funeral Director	10e. Street and Number 930 Southern Ave	.,S.E.		Zip Code			-	of What Cou	ntry?
9600	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 Never Married 2 Married 1	Vas Decedent Ever in U.S. vas Decedent Ever in U.S. varied Forces? Vas 2 1 No Yes, Give year or Dates.	If Yes, sp	edent of His ecify Cuban 2 🙀 No	panic Origin? (Spe , Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		Race - Ameri Black, White, ecify: Bl	
21215-0036	ithin 72 hou ene. • than "nat he Medica	Completed by	15. Decedent's Education (Specify only highest grade continued in the secondary (0-12) Continued in the seco	mpleted) ollege (1-4 or 5+)	6a. Decedent's Us (Give kind of w life. DO NOT L Farmer	vork done du	tion uring most of worki	ng		of Business Ir	-
Maryland 2	ild be filed within Mental Hygiene. narked other tha iatic event, the M	To Be (	17. Father's Name (First, Middle, Last)  Calhoun Baxter, Jr		Idinei		18. Mother's Name	e (First, Middle, S Mack			
, Man	d 2 should salth and Me n 27 is mar er traumati		19a. Informant's Name/Relationship (Type, Pr Albert L. Baxter/Son	· ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	19b. Mailing Addre		od Number or Rura				Code)
Baltimore,	bage ent c nt: If		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State ceme	e of Disposition (Netery, crematory of eake Cre	other place	) !	Date /18/11		tion - City or T sville	
Balt	permit. Pag Departmen Important; any injury o	1/2	21. Signature of Funeral Service Licensee	Quat	22. Name He 4925	and Address Nry S Burrou	washing aghs Ave	ton & S	Sons C Vashin	o, Inc gton, D	.c. 20019
-1	Pnysician/	- 10	23a. Part 1/Enter the disease, or complication shock, or heart failure. List only one caul Immediate Cause (Final disease or condition	ons that caused the death. Do se on each line.	o not enter the mo	ode of dying.	such as cardiac c	r respiratory an	rest,		Approximate Interval Between Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a consequence	Comme	tro	1				1 hr
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_	ificate be executed g physician and as the burial-transii		that initiated events c. — resulting in death) Last	Due to (or as a consequence	ce of):						
8760	ficate g phys as the	Medical	d		=-						
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months?	yes, outcome of pregnancy  Live Birth 2 Fetal dea  Pregnant at time of death Unknown					230	I. Date of deliv	rery Day Year
s, P.O.	ires that th signed by Id be detac	ρ	Part II. Other significant conditions contribu	ting to death but not resulting	g in the underlying	g cause give	n in Part I.				he cause of death?
Division of Vital Records, P.O.	sician: The law reques certificate has been lirector, page 2 shou	Completed			_			24a. Was autop perfo	rmed?		ppsy findings available ompletion of cause of
tal	cian: T	Be	25. Was case referred to medical examiner?	ol:			ce of Death (Check		2 - 110	1 103	2 🗆 110
ζ	nding Physician: Th. After this certifica funeral director, p	e: 1	T LI fes 2 A No	1 Inpatient 2 ER/0	Outpatient 3 🗌	DOA Other 28c. Injury	4 Nursing Ho	me 5 Resid			/)
ono	ending sath. or: Afte he fune	ficat	1 ☒ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury M	work?	es 2 🗆 No	Log. Describe II	ow injury oc	ourrou	
Divisi	tal or Atter safter de al Directo ed in by t	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of Injury - At home, building, etc. (Specify)	farm, street, facto	ory, office		28f. Location (S City or Tow		umber or Rura	l Route Number,
	he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2   Medical Examiner: O	To the best of my knowledge in the basis of examination and tioner. To the best of my tho	d/or investigation, in	n my opinion	, death occurred at	the time, date a	nd place, and	d due to the ca	use(s) and manner stated.
	Vith Con		29b. Signature and title of certifier	19(2m &		oc. License r				gned (Month,	
7		S	30. Name and address of person who comple	ted cause of death (Item 23a	(Type, Print)	4927	3857° Lasall	, PJ	HU	attend	10 1111
	Stat Registra		31. Date filed (Month, Day, Year) Leave	32. Registrar's Signature	W		14×(11	W NCI			1014

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amend State of Maryland / Department of Health and Mental Hygiene 201 34785

		- For State Cert	ificate of	f Death			Reg. No.	
Physiciar ledical Examin	n/	Decedent's Name (First, Middle,Last)  Nahshon O'Brian Bart	nett			2. Date of De Month October	eath Day Yea	3. Time of Death 0505 hrs
		la. Facility Name (if not institution, give street and number) Suburban Hospital	1	4b. City, Town, or Bethesda	Location of D		4c. County Montgor	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year Months Day			Birth (MM/DD/YYY)	9. Birthplace (State or Foreign Country) Maryland
*ny	-	Jsual Residence of Decedent	Yrs own or Locat			Febr	uary 5,	10d. Inside City Limits
<b>E</b>	٦	3	Rockvi					1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	304 Cedar Lane		10f. Zip Code 20851			10g. Citizen of Wi	
72 hours after death with the Maryland n"natural", or items 23a or 28a-f she al Examiner must be notified at once	L	1. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 No			spanic Origin	? ( Specify Yes or I uerto Rican, etc.)		e - American Indian, Black, le, etc.
s after d	by F	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 🗆	Yes 2 X No				Black
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15-0036 filed within 72 If Hygiene. ed other than t, the Medical	Completed	12th grade 7. Father's Name (First, Middle, Last)	1	Unemploy		Jame (First Middle	No., Maiden Surname	one
	8	Randolph Barnett			Mar	va Joy	<b>Kelly</b>	
MD 212. d 2 should be tth and Menta n 27 is market numatic even	٩	9a. Informant's Name/Relationship (Type, Print)  Marva Joy Kelly (Mother)					umber, City or Tow ryland 20	wn, State, Zip Code)
구 경 등 등 등		20a. Method of Disposition 20b. Pl		ition (Name of ce		Date	-	- City or Town, State Wash. D
Baltimore, permit. Pages I an Department of Hee Important: If ite				leaven C				ver Spring,MD any Morticians,
Bal permi Depa Impo		Landy B. Hart						hington,D.C.200
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.	Do not enter ti	he mode of dying	, such as card	iac or respiratory e	errest, shock, or he	eart Approximate Interval Between Onset and Death
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	٦	Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):						
	E١	c.  Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						_
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8760, ifficate be en appropriate but as the burial		F FEMALE: 23c. If yes, outcome of pregna	ancy				23d. Date o	f delivery
Sox 687 leath certific e attending p	cian/	3b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of deal	th	tal death 3 her (Specify)	Ectopic pr	regnancy	Month	Day Year
Box 68.  he death certi the attendin he for use a	≥∟	Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not res			niven in Dart I	Lago Die	I tobacco use cont	ribute to the cause of death?
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Jof Jing Ph		27. Manner of Death   28a. Date of Injury   1   Natural   5   Pending   Oct 8, 2011	28b. Time of I 0415 hrs	.	ıry at Work? Yes 2 ✔ No	Dassanda	e how injury occur r in car/tree in	
Division ital nr Attendi urs after death. ral Director: A		2 V Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street		et, factory, office	building, etc.	or Town	State)	ber or Rural Route Number, City nbrook Parkway, Rockville, M
	ल्र	9a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner:On the basis of examination and						
T. viří	¥ :	and manner stated.		29c. Licen:				ned (Month, Day, Year)
		D Name and address of person who completed cause of death (Item 2	?3a)	O.C.	M.E.		October 8	, ZU11 
		Laron Locke MD. Assistant Medical Examiner	900 W. Ba	altimore Stree	et, Baltimo	re, MD 21223		
Star Registra	te ar	11. Data-filed Moeth Day Year 32. Registrar's Signatur	all					
DHMH 17 Rev 1/200 DCME 2006	)1	OCME	ORIGINA	L				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g929 7-5-12 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:20 PM **Physician** 2011 10 Kathryn McDade CARR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Favenwood Lutheran Village Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Jan. 12 7. Age (In vrs. last birthday) **Funeral** New Jersey Days Hours 1 ☐ M 2 🂢 F 98 1913 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if Item Medical Evantist croust be notified a gone. 1 ▼Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA by Funeral 21740 1183 Luther Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Her own home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie L. Summa Michael F. McDade ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12409 Needle Drive, Clarksburg, Maryland 20871 Edward F. Carr, Jr. - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 10/20/11 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Kenne 23a. P. T.T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** are broyan /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 27. Manner of Death
Natural
2 ☐ Accident 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide \*Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of could who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Northern And Wagen town Mahmord MD 580C 31. Date filed (Month, Day, Year)
OCT 91 200 32. Pegistrar's Signature State

Registrar
DHMH 17 Rev 1/2001

Registrar

State

WRNMMC, BETHESDA, MD 20889 5600

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN A BOLANOS

13 2011

MC USN

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3, Time of Death 1. Decedent's Name (First, Middle, Last) 10 Month 10<sup>Day</sup> 1<sup>Year</sup> Physician/ 22:33 P M CASTRO MODESTA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery CO. Silver Spring HOLY CROSS HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 07-14-26 1 □ M 2 🔀 F Days Hours Min. ELSALVADOR Director 85 Unknown Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at Director 1 X Yes 2 No Md Montgomery SILVER SPRING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral ELSALVADOR 20902 12211 Centerhill ST. tems death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ ò 1 Never Married 2 Married 1 Yes Maryland 21215-0036 TX☐ Yes 2☐ No SpecifyELSALVADORIAN Specify: White "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Never Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H မ MAXIMA CASTRO CALIXTO AQUILAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i (Daughter) 12211 Centerhill ST. Silver Spring Md.20902 DOLORES REYES Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 10-19-11 **ELSALVADOR** Family Cemetery 4 Donation 5 Other (Specify) 21. Sonature of Funeral Service Livense INC. W.H. BACON FUNERAL HOME TUCLA 3447 14th ST. NW WASHINGTON D.C. 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner NSTEMI(Non-ST segment elevation myocardial infarction) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 the IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) in the past 12 months? ō Day Year Pregnant at time of death 2 🔀 No Yes the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4X Unknown PNEUMONIA Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? ACUTE RENAL FAILURE 24a Was an has autopsy performed? 1 Yes 2 No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🕱 No မ 1 Maligner 1 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpat 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in Earth. 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

D68096

Holy Cross Hospital 1500 Forest Glen Rd SilverSpring, MD 20917

MI

Satyan 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-11-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4c Per PHY &10b Per INF G926 4/06/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 10, Day 2011 Courtois Bernard 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Prince Georges Silver Spring Renaissance Gardens 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 😿 M 2 🗆 F Months Days Hours May 21 3 1920 New York 571-36-8889 91 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Prince Georges Silver Spring Maryland 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road 20904 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' ģ 1 Never Married 2 Married Black, White, etc. 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Dept. of Defense Procurement Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rose (unk) Mark Courtois 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Dawn View Court., Silver Spring, Maryland 20904 Gary Courtois - SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National Mem. Park 10/18/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral S Licensee Fleck Flateral Holle, INC. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Atrial Fibrillation disease or condition resulting in death) Medical Due to (or as a consequence of): kaminer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal 300.

Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year signed by the at d be detached for 1 | Yes 2 L 9 | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease 1  $\square$  Yes 2 X No 3  $\square$  Probably 4  $\square$  Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 2X No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Tes 2 🗌 No Accide... Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ulular October 10, 2011 D0036716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, MD. 3110 Gracefield Road. Silver Spring, Maryland 20904 31 Date filed (Month, Day, Year) 32. Redistrar's Signature State OCT 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34790 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Imer! Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner mundel TNNAPOLLS Med If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**XX**M 2 D F Months Davs Hours 1272871948 126-40-3748 62 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes XX No Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 Funeral 1289 Hardy Rd. USA 12. Was Decedent Ever in U.S. Armed Forces?

144 Yes 2 No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. þ XK Never Married 2 Married White 1 Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced Vietnam Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Builder 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Jean Pultz Lois Chimeri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Friend Craig Offhaus 1289 Hardy Rd. Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/14/2011 Glen Burnie, MD Crematory 21. Signature of Funeral Service dicensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 7 Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Interval Between Onset and Death Immediate Cause (Final Physician 105 clevatic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 KER/Outpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier epu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7:03 Month Year Physician/ CAMPBELL 10 LORRAINE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES HOSP MAL CENTER CHERVERLY PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 😿 F Months Days Hours Min. Washington DC 577-62-6708 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ within 72 hours after death with the Maryland Director must be notified X☐ Yes 2 ☐ No DC Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a Funeral States 5406 Illinois AVE 20011 items NW11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc. o. 1 X Never Married 2 Married by Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th grade Homemaker traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or one 2 Grace Fountain Raymond Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramblewood Dr. District Heights Md. 20747 <u> Stephanie Harris – Daughter</u> 2107 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) incoln Cemetary 10/25/2011 Brentwood, MD 22. Name and Address of Facility Johnson & Jenkins FuneralHome tur of Funeral Service Ligense 716 Kennedy ST NW WDC 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Se wentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death ed by the detached P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has page 2 s autopsy perform death? r this certificate had 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **W**No ျှ 1 Yes npatient 2 ER/Outpatient 3 DCA 24 hours after death.

Funeral Director: After thi leted filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Natural 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my animal data. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James John Carey 4:00 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 7. Age (In vrs. last hirthday) Days (Month, Day, December 1 ፟ M 2 □ F Hours 93 040-18-9326 Whately, MA **Director** Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Maryland Prince George's Adelphi 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 3210 Powder Mill Road 20783 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates. 1942–1946 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r within 72 Immigration and Elementary/Seconday (0-12) College (1-4 or 5+) INS Officer Naturalization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James John Carey Anna Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7200 Wolverton Court, Clarksville, MD 21029 Alan B. Carey / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 10/19/2011 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Guylle RAY Rogers Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition neumon Medical resulting in death) Due to (or as a consequence of) Examiner works Obstructor Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit estive and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 No the g 🗌 Unknown detached 9 Unknown Division of Vital Records, P.O. ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypeetrophy Benign Rostatic 1 Yes 2 No 3 Probably 4 Unknown Completed Peropleme acternal disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform director, page 2 Dystipidentia certificate 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t 28d. Describe how injury occurred Certificate: Natural 5 Pending Investigation Accident after death 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical 1 🗲 wrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place and place, and due to the cause(s) and manner stated
3 Contribute Number Praction on the loss of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Contribute Number Praction on the loss of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 To the I 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 215+1 Carroll Are Takana Pack, MD MD 7600 31. Date filed Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

OCT 1 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Winifred Donoho October ľÖ, 2011 6:41 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 4, 1934 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🕱 F Days Min 77 Yrs Director 579-48-7092 Usual Residence of Deced shov or 28a-f shov notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Silver Spring Montgomery ems 23a or r must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11600 Orebaugh Avenue 20902 Department of Health and Mental Hygiene.
Important: If item 27 is marked out. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🛣 No If Yes, Give Year or Dates 1 ☐ Yes 2 Tho Specify Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Synagogue Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Whitton Black Agnes Isabel Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Earle Donoho/Son 2119 Arcola Avenue, Silver Spring, MD 20902 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 0ct 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2011 Alexandria, VA Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 phi to MO1505 23a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence on. Exami Atrial Fibrillation Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hypertension Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?
1 Yes 2 No Dav Year the 9 Unknown 9 Unknown P.O. ed by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes ပ္ 2 XNo Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

State Registrar

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29a. Certifier

(Check

31. Date filed (Month, Day, Year) 13 2011 OCT

29b. Signature and title of certifier

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Gebremedhin Yohannes, MD

1500 Forest Glen Road, Silver Spring, MD 20910

mais

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Donnenfeld 03, 2011 Medical Bever1v Francine October 0 3:49 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8517 River Rock Terrace Bethesda Montgomery If Under 1 Year If Under Months Days Hours Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 117-28-5059 1 □ M 2 🕱 F 73 11/14/1937 New York Usual Residence of Decede 28a-f show 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d, Inside City Limits Director 1 X Yes 2 No Bethesda MD Montgomery 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8517 River Rock Terrace IISA 20817 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates White the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Artist Art 54 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Nathan Tobias Charlotte Modick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i 7317 Heatherhill Ct. <u> Mara Hannula / Daughter</u> Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date of cemetery, crematory or other place)
Judean Ξ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/06/2011 Olney, MD Memorial Gardens 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels Inc. MO1477 Kurt Blake 1170 Rockville Pike Rockville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Ph\_sician/ Small Bowel Obstruction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 3 To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) buria physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy φ in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Dav 2 X No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bladder Cancer with Metastasis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 N 2 🗌 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5X Residence 6 Other (Specify) npletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pendina injury work?
1 Yes 2 No after death 2 Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

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DHMH 17 Rev 06-2011

2021 K Street, NW, Suite 404

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signa

Jeffrey Sherman, MD

13 2011

31. Date filed (Month, Day, Year)

D37059

October 5, 2011

Washington, DC 20006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland 1-For State Registrar	-	tificate of		u wenta	ii riygiene	Reg. No	201	1 31.70
Physicia	ın/	Decedent's Name (First, Middle,Last)				<del></del>	2. Date of I			3. Time of Death
ledical Exami	ner	Donna Davis  4a. Facility Name (if not institution, give street and number	5)		4b. City, Town, or	Location of F	Octobe	r 16, 20		0944 hrs
		Southern Maryland Hospital	r) 	ľ	Clinton	Location of L	Deall		Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 7. A 6. Sex 1 7. A 6. Sex 1 7. A	ge (In yrs. Ia $47$	ast birthday) Yrs	Months Day		A Circ	Birth(MN 2 – 1 9	964 964	rthplace (State or gn Wash, Duntry) D.C.
aoy		Usual Residence of Decedent  10a, State 10b, County	Inc. City	Town or Locati	ion					10d. Inside City Limits
<b>E</b>	_	MD P.G.	100. 01.9,		per Ma	rlbor	0			1 Yes 2 No
arylan 8a-f s	Director	10e. Street and Number	<u> </u>		10f. Zip Code	11001		10g. Ci	tizen of What Cou	intry?
the M		9903 Rosaryville RD.			2	20772			U.S.	Α.
th with	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces					? ( Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame White, etc.	rican Indian, Black,
er dear			2 <b>X</b> No		Yes 2 X No		,			.ack
urs aft tural'	d b	15. Decedent's Education (Specify only highest grade or	ompleted)	16a, Deceden	t's Usual Occupa	tion (Give kin	d of work done	16b.	Kind of Business	/Industry
6 172 ho	Completed	Elementary/Secondary (0-12) College (1-4 or	r 5+)	during m	ost of working life Clerk	e. DO NOT us	e retired)		Cover	nment
OO3 withir giene.	E O	17. Father's Name (First, Middle, Last)			Cierk	18 Mother's N	Name (First, Midd	le Maider		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f she injury or other traumatie evect, the Medical Examiner must be sotified at occ	Bec	Theodore Williams					masine		,	
21 hould land Mer is mar	٥	19a. Informant's Name/Relationship (Type, Print )							City or Town, State	
, ML sand 2 s ealth are cen 27		Richard Davis (Husban			Landov ition (Name of ce		Date		everly l	MD.20785
Baltimore, permit. Pages 1 ar Department of Hee Important: Uite injury or other tr		1 X Burial 2 Cremation 3 Removal from S	State C	rematory or oth	ner place)	l <sub>1</sub>	0-24-1		rentwoo	
nit. Pa artmen		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	FT	. Lino	coln Ce	s of Facility	Hunt Fr	nor	al Home	20044
Dep Dem		Francis B. Hunt		90	8 Kenn	edy S	t. N.W.	Was	shingto	20011 n, D.C.
Physician Magical		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.				such as card	liac or respiratory	arrest, sh	nock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Occlusive Pulr  Due to (or as a con			oolism					Death
		Sequentially list conditions,  b. Deep Vein Thr			er Extremity					
	ine	if any, leading to immediate Due to (or as a concause. Enter Underlying Cause	soquence of	).						
it d	Examiner	(Disease or injury that initiated events resulting in death) Last   Due to (or as a con	sequence of	):						
Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - transit	Ea E	d d								-
60, tte be ex hysician e burial	Medical	IF FEMALE: 23c. If yes, outcome	ome of prean	nancv				23	3d. Date of deliver	\
30x 6876 leath certificate e attending phy for use as the b	an/	past 12 months?	at time of dea	2 Fe	tal death 3	Ectopic pr	regnancy			Day Year
Box 6876  The death certificat  The attending phice of the control	Physician/N	1 Yes 2 No 9 V Unknown 9 Unknown	at time of dea	5 Ott	her (Specify)					
ires that the signed by the I be detached	된	Part II. Other significant conditions contributing to dea	ath but not re	sulting in the u	inderlying cause	given in Part I		_		the cause of death?
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Cords, law requir has been s	Completed							ras an utopsy erform <u>ed</u> ?	prior to	utopsy findings available completion of cause of
tal Rec sino: The l certificate l ector, page							1 🗸 Y	s 2 1		es 2 No
Vital ysicino his certi	a	25. Was case referred to medical examiner?  Hospital:   Input	ient 2	ER/Outpatient		Other :	neck only one)  Jursing Home 5	Resid	lence 6 Othe	
IVISION Of Vital I or Atteodiog Physiciao: after death. Director: After this certifi in by the funeral director,	١	27. Manner of Death 28a. Date of In	iury	28b. Time of Ir		ry at Work?			jury occurred	
ion tteodi leath. tor: /	aţi	1 V Natural 5 Pending 2 Accident Investigation	,,		1 🗆	Yes 2 No	0			
Division of Vital Records, pital or Atteoding Physician: The law requinours after death.  Peral Director: After this certificate has been sifilled in by the funeral director, page 2 should be	Certification:	Suicide Could not be determined (Specific)	Inju <b>ry - A</b> t ho	me, farm, stree	et, factory, office I	ouilding, etc.		n (Street n, State)	and Number or R	ural Route Number, City
		4 Homicide  29a. Certifier A Continue Physician To the heat of	nv knowleda	e. death occur	red at the time. d	ate and place	and due to the o	ause(s) a	ind manner as sta	ted.
To the Hos within 24 h To the Fuc	Medical	(Check only one)  2 Medical Examiner: On the basis of example and manner stated	amination an							
F × F ō	ž	29b. Signature and title of certifier			29c. Licens				Date signed (Mo	
		m w.			O.C.	M. <b>∟</b> .		Oc	tober 17, 201	1
28		<ol> <li>Name and address of person who completed cause of Ling Li, MD Assistant Medical Examine</li> </ol>			e Street, Bal	timore, ME	21223			
Sta Regist	ate	31. Date filed (Month, Day Year) 32. Registr	ar Signat	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Ameno#7.19b.PerFHPCC10-19-11cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1<sup>2</sup>2, October 2011 7:10 ECKS S. DIXON SR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 71 Yrs. **Director** 1 XM 2 - F Jacksonville, 246-54-1126 Usual Residence of Deced 10/26/1939 North Carolina or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges Hyattsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 2510 Woodberry Street 20782 United States Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Professional Truck Driver Private 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David M. Dixon မ Celia Pollack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elvira Dixon / Wife 2510 Woodbury ST Hyattsville MD. 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any injury or Maryland National 10/22/2011 Laurel, Maryland 21. Signature of Funeral Service Dcensee 22. Name and Address of Facility 22. Name and Address of Facility

Johnson & Jenkins Funeral Home 716 Kennedy luka ST NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ Community Acquired Pneumonia disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying months Examine Due to (or se a consequênce of, the attending physiclan and ched for use as the burial-transit 2 months Cause (Disease or injury Adult Respiratory Distress Syndrome that initiated events resulting in death) Last Physician/Medical Urosepsis that the death certificate be months Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Type II Diabetes Mellitus 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Cardio Vascular Accident in 2008 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Inĵury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 XNatural 5 Pending iniury Accident
Suicide Investigation completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 10/12/2011 REW MD D0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Ann Supanich, MD Holy Cross Hospital 1500 Forest Glen Road 31. Date filed (Month, Day, Year 0CT 1 9 2011 32. Regist r's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Erma FENYUS Ctobe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours 1 M 2 X F 92 Pennsylvania 194-14-5488 Yrs Feb. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland a 10c. City, Town or Location Director items 23a or 28a-f s ner must be notified 1X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 426A W. Washington Street al Hygiene. of other than "natural", or items event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) her own home 10 homemaker event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Joseph Capasso Page 1 and 2 should be Filomena Cenname traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Cheryl Jae - daughter 426A W. Washington St., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 10/19/11 Hagerstown, Maryland 4 Donation 5 Other (Specify) Hagerstown Crematory 21. Signature of Euroral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ Myocardial avetor disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit GASTRO INITESTINIM and Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year Other (specify) Pregnant at time of death been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has l autopsy performed Yes 2 2 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 1 Yes 2 No ပ 1 7 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 3 only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 160 AD MKEMIDWN MD 21740 UMIR GIMZAUA MT ALAWA 31. Date filed (Month, Day, Year) State Table . Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ 5:13 PM Edward Foushee October Henry 7011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Hours 1 🛛 M 2 🗆 F Months August 4.1928 North Carolina 83 Yrs 144-20-0776 Director Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d Inside City Limits Director must be notified 1 X Yes 2 No Maryland Hagerstown Washington 10e. Street and Number 10f. Zip Code þ 10g. Citizen of What Country? 23a Funeral 14132 Shelby Circle 21740 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces Black. White, etc. 150 ☐ Yes 2 ☑ No Specify: 1 X NeverMarried 2 ☐ Married "natural", or þ 1X Yes 2 No If Yes, Give OCt Year or DatSept 3altimore, Maryland 21215-0036 72 hours after 12 Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 1 and 2 should be filed within 72 of Health and Mental Hygiene.
 f item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housing Complex Maintenance 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Foushee Viola Smith Carl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14132 Shelby Circle, Hagerstown, Md. 21740 Renelle Foushee Niece Department of He Important: If it any initial 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10-21-11 Newark, New Jersey 4 Donation 5 Other (Specify) Fairmount Cemetery 21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, R. hoel. Bra Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ACUTE My Oca di disease or condition resulting in death) Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Directo (or este incresquente or; The law requires that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months Month Day Year Pregnant at time of death ed by the a Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed certificate | 2 No Yes 2 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after To the Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

IW 5+1 State

Registrar

(Check

FRANCI 31. Date filed (Ma

29b. Signature and title of certifier

muy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

To the I

complet

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Merins

29c. License number

40061117

Medical

Medical

Examine

Physician/Medical

Completed by

Be (

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Certificate:

Medical

29a. Certifier (Check only one)

Director

Funeral

Completed by

Be

မ

Physician/

Medical

**Examiner** 

**Funeral** Director

Pleas	se Type or Prir					_	е.
For State	State of Ma	aryland / Depa <i>Cer</i>	ertment of b			001	1 01 70
Registrar  1. Decedent's Name (First, Middle,	Last)	Ce.	. uncate Of		2. Date of Death	eg. No. 201	3. Time of Death
ELIZABETH M. FI	•				OCTOBER	15 201	
a. Facility Name (if not institution,			4b. City, Town, o	or Location of Death		4c. County of De	Death
CORSICA HILLS	NURSING HOME		CENTRE	VILLE		QUEEN AN	NNE'S
. Social Security Number 137–12–6769	6. Sex 7. Age	e (In yrs. last birthday)  Yrs.	If Under 1 Year Months Days			9. 1916 NI	Birthplace (State or Foreign Country) EW JERSEY
Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	ocation				10d. Inside City Limits
MD QUEEN	ANNE'IS	CENTREVI	LLLE				1 X Yes 2 ☐ No
100 S. LIBERTY			10f. Zip Code	21617	10	0g. Citizen of What USA	
11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces?	No.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	oan, Mexican, Puert		Black, WI	American Indian, Vhite, etc. WHITE
15. Decedent (Specify only highes Elementary/Seconday (0-12)		(Give i	edent's Usual Occup kind of work done OO NOT use retired)	during most of wor	rking 1	16b. Kind of Busine	ess Industry
Elementary/Seconday (0-12)	College (1-4 or 5-4	0+)	HOMEMAKER	_		OWN HON	ME
17. Father's Name (First, Middle, La				1	ame (First, Middle, Ma DAH SICKLE:	•	
19a. Informant's Name/Relationshi	ip (Type, Print)				ural Route Number, C		
20a. Method of Disposition  1 □ Burial 2 ▼ Cremation 3  4 □ Donation 5 □ Other (Sp.	3 Removal from State	20b. Place of Dispo	osition (Name of		Date 2	20c. Location - City	
21. Signature of Euneral Service Lic		/ FF	2. Name and Addre	ess of Facility ELFENBEIN	& NEWNAM	FUNERAL ILLE. MD	HOME, P.A. 21617
23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line.	the death. Do not ente					Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a	a consequence of:  Jen Si on a consequence of:	lar m	suffici	ency		years years
	La Ather	o sclenos!	<u>*</u>				years
F FEMALE: 23b. Was decedent pregnant in the past 19 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnan☐ Other (s <i>pecify</i> ) _	ıcy		23d. Date of Month	f delivery Day Year
Part II. Other significant condition	ns contributing to death b.	ut not resulting in the (	underlying cause 9	iven in Part I.		acco use contribute	te to the cause of death?
					24a. Was an autopsy perform	y prior death	e autopsy findings available to completion of cause of th?  Yes 2 \sum No
5. Was case referred to medical			26. P	Place of Death (Che	7	7	NV S S S NV
examiner?	Hospital:	ent 2 ER/Outpatier	_ Oth	l	Home 5 Residen	nce 6 Other (St	oecify)
7. Manner of Death  Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	ry 28b. Time of	of 28c. Injur	ıry at	28d. Describe how		
3 Suicide 6 Could n 4 Homicide determin	not be 28e Place of Injur	ury - At home, farm, street, (Specify)			28f. Location (Stre		r Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

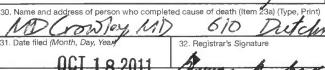
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Catherine Royster Franklin October 13, 2011 9:15 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Riverdale Crescent Cities Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeal) 919 **Funeral** Months Days Hours Min. 1 □ M 2 K F 92 February 22, Director 578-38-9384 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Director Maryland Prince Georges Bladensburg the 10f. Zip Code 10g. Citizen of What Country? 20710 United States 4101 - 53rd Place; Apt. 1 by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) **6th grade** College (1-4or 5+) Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fil Health and Mental H tem 27 is marked ot Square Babe Royster Cora Rell Johnson Ith and Menta 27 is marked traumatic e ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4101 - 53rd Place; Apt. 1; Bladensburg, Maryland 20710 Melvin Royster, Sr. (Son) other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott t, 20, 2011 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 4 □ Donation 5 □ Other (Specify) Washington, D.C. 21. Signature of Funeral Service Ligans to 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 2 **N** No 2 □No 1 □ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After t d in by the funera 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) ind manner stated.

State DHMH 17 Rev 1/2001 29b. Signature and title of certifie

Saadia Husain, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4409 East

32. Registra Signa

29c. License number

D0064208

West Highway; Riverdale, Maryland 20737

29d. Date signed (Month, Day, Year)

October 13, 2011

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State		Sti	ale of t	nai yiai i		tificate of l				_	0.1.1	0'001
		Registrar  1. Decedent's Name	e (First, Middle,	Last)				timouto or .	Joann		2. Date of Dea	Reg. No. 2	<del>U + +</del>	3. Time of Death
Physicia Medic		Ursu1a	Katari	na	Stein	berg	Giore	dano			OCTOBEI	R 08	$201^{\text{Year}}$	3:00 p <sup>M</sup>
Examine	_	4a. Facility Name (if			and number,			4b. City, Town, a	r Location	of Death			unty of Death	
,		Wilson H			1-			Gaithe					ntgome	
Funeral Director		5. Social Security N 093-26-8 Usual Residence of	544	6. Sex 1 \(\sum M\) 2	2 <b>X</b> ) F	83	ast birthday) Yrs.	If Under 1 Year Months Days	Hours	er 24 Hrs. Min.	8. Date of Birl (Month, Da DEC 29	, Year) 1927	Cour	nplace (State or Foreign ntry) Germany
show show	5	10a. State	10b. County			10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Maryla 18a-f	Funeral Director	MD	Monte	gomery		Mon	ntgome:	ry Villag	e					1 🗆 Yes 2 🗓 No
a or 3		10e. Street and Nur	nber					10f. Zip Code				10g. Citizen	of What Cou	intry?
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r dea	by Fu	<ol> <li>Marital Status</li> <li>Never Marr</li> </ol>	ied 2 Marri	12. Wa	as Deceden med Forces Yes 2	t Ever in U.S		Was Decedent of H f Yes, specify Cuba	Hispanic Or an, Mexica	rigin? (Spe an, Puerto l	cify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
s afte ral", d Exan	q pa	Widowed		If \	ום זפט ∠נ Yes, Give ar or Dates.	_1 MO	1	1 ☐ Yes 2 🔀 No	Specify	y:		Spe	ecify:Cauc	asian
"natu	Completed	(Spe	15. Deceden				16a. Deced	dent's Usual Occup	oation	et of working	20	16b. Kind o	of Business Ir	ndustry
than 75	E O	Elementary/Sec		1	llege (1-4 o	r 5+)	life. D	O NOT use retired)	)	St Of WORK	rg		77	
ed wit Hygie other ent, th	Be	17. Father's Name (	First, Middle, L	ast)	5+		House	ewife	18 Mot	hor's Name	(First, Middle,		Home	
be fil ental rked o	卢	Hans Eri		*							e Doroi			
hould and M is ma		19a. Informant's Na	ame/Relationsh	ip (Type, Prir	nt)		19b. Mailir	ng Address (Street	and Numb	ber or Rura	Route Numbe	r, City or Tow	ın, State, Zip	Code)
nd 2 s ealth a m 27 i		Manuel F	erre He	cker	/ Nep	hew	Mande	olinagen	47,	17556	Jarfal	la, Sto	ockho1r	m, Sweden
t of Harliter		20a. Method of Disp 1 D Burial 2	oosition X Cremation	3 Remov	al from Sta	20b. F		sition (Name of matory or other pla			ate	20c. Locati	ion - City or T	Town, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation	5 Other (S	pecify)		At		Cremato			/2011		Burnie	, MD
permir Depar Impor any ir		21. Signature of Fu	neral Service I	gensee		M0095	6	Thibadeau 7 Park Av	ess of Facilities Mor Venue	tuary , Gai	Servio	ce, P. urg, M	A. D 2087	7
			rt failure. List o	complication nly one caus	ns that caus se on each li	ed the deat ne.	h. Do not ente	er the mode of dyir	ng, such as	s cardiac o	r respiratory an	rest,		Approximate Interval Between
Physician/ Medical		Immediate Cause ( disease or condition resulting in death)		a	Kes	pira	atar	y fact	use	ン				Onset and Death
Examiner		resulting in douting	Ĭ		Due to (of/a	s a consequ	uence of):	The CH	· a	who	mai	41		
	ner	Sequentially list co if any, leading to im	nmediate	b. —	Due to (or a	s a consequ	uence of):		V		- Comment	7	reace	
be executed sician and burial traveit	cal Examiner	cause. Enter Under Cause (Disease or that initiated events	iinjury	c							•			
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicampleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE:	prognant	23c. If y	ves, outcom	e of pregna	incv					00.4	Data of dati	
atten I for u	iciar	23b. Was decedent in the past 12 I 1 \sum Yes 2	months?	1 [	Live Birth	2 Feta	al death 3	Ectopic pregnand Other (specify)	су			230	I. Date of deliments  Month	Day Year
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s that gned I	by F	Part II. Other signif	ficant condition	ns contributi		4						/		the cause of death?
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law re has be e 2 sh	nple	rejec	slipid	eni	ea.	Vita	mi	n O			24a. Was autoj	osy	prior to co	opsy findings available ompletion of cause of
r: The icate r, pag		25. Was case referre	icun	ug.	Hay.	Pope	nie	L			1 🗌 Yes	2 No	death?	2 🗆 No
siciar certifirecto	To Be	examiner?	No	Hospita	ul:	· · · · ·	ED/6	Oth	or.	eath (Check				
g Phy er this heral d		27. Manner of Death	h		a. Date of in	jury	ER/Outpatier 28b. Time of	28c. Injur	ry at	$\overline{}$	me 5 Resident			<u>fy)</u>
endin sath. or: Aft he fur	ficat	1 M Natural 2 Accident	5 Pending	ation	(Month, E	ray, rear)	injury	M 1 -	k? ]Yes 2[	□No				
or Att fter de irecto n by t	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determi			njury - At ho etc. (Specify		eet, factory, office			28f. Location (\$ City or Tow		ımber or Rura	al Route Number,
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e Hos n 24 h e Fun sleted	Medical	(Check 2	🖳 Medical Ex	caminer: On	the basis of	examination	n and/or invest	occured at the time tigation, in my opini death occurred at th	on, death of	occurred at	the time, date a	and place, and	d due to the ca	ause(s) and manner stated.
Withir to the state of the stat		29b. Signature and						29c. Licens	e number			29d. Date si	igned (Month,	, Day, Year)
		MAR	2 herz	bur	sch	hor	fue	0	411	5		Getro	res 9,	2011
		30. Name and addre	ess of person w	/ho complete	ed cause of	death (Item	28a) (Type, F	Print) 24	010	us.	5846	4,00	NUE	2011
State		31. Date filed (Monti	BELT. h, Day, Year)			trar's Signa		64	17-	12 R.S	BURG	o, or	L 20	1001
Registra	•	00	T 13 2	011	Endus		par	KI.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:15 P AWYNN VIVIE 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nester Dorc ambridge If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖼 Hours Min. (Month, Day Months Days Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 es 2 No 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Funeral 21613 Meteor Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis 19a. Informant's Name/Relationship (Type, Print) Dueshter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trans Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory of other place) 1 Burial 2 Cremation 3 Removal from State 4. ☐ Donation 5 ☐ Other (Specify) Chrerch Creek 10-20-201 22. N me and Address - racility CUNTEN-Bromwell - uneral Home, of Funeral Service Liminsee Campriles. MO21613 tent 1 enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ m nosom disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year 1 Yes 2 No 9 Unknown Pregnant at time of death g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performe 1 ☐ Yes 2 🔽 o 25. Was case referred to medical examiner?

1 Yes 2 Division of Vital Be 26. Place of Death (Check only one) Hospital 4 Wursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred 28c. Injury at work? 1 Natural iniury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date sinned (Month, Dav. Year) 2011 completed cause of death (Item 23a) (Type, Print) e and address of person hi

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (A

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 0259 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis Somerford Assisted Living 9. Birthplace (State or Foreign North) Carolina 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number Months Days Hours Min. 8/26/1937 240-56-2919 74 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a. State Annapolis Anne Arundel Maryland 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21403 124 Boyd Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 Never Married 2 XMarried White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineering Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Ruth Gold Dargan Evans Grigg 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Boyd Drive, Annapolis, MD 21403 Rebecca Grigg - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2XI Cremation 3 🗆 Removal from State 10/11/11 Baltimore, MD Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses Musein T. Vilolian 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 00 1291 disease or condition resulting in death) Due to (or as a consequence f):

tran and ng physician a as the burial-t Division of Vital Records, P.O. Box 68760 cate has been signed by page 2 should be detacl After this certificate has funeral director, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral

Physician/

Medical

Director

Funeral

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**Examiner** 

**Funeral** 

Director

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23a

Examiner must be notified

יוישיו בנו s marked other than "natural", or i other traumatic event, the Medical Examin

2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r

je 1 and 2 s t of Health a If item 27 i

permit. Page 1
Department of
Important: If it
any injury or o

Physician/

Medical

Examiner

Physician/Medical

Completed by

Be မ

Certificate:

Medical

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 1 4 2011

ARROTT

Examiner

Baltimore, Maryland 21215-0036

within 72 hours after

Sequentially list conditions, if any, leading to immediate caucous interventions or linjury.  Cause (Disease or linjury	Due to (or as a consequence of):		
that initiated events resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy  1	23d.	Date of delivery Month Day Year
	tributing to death but not resulting in the underlying cause given in Part I.		contribute to the cause of death?
Hsa Dro	ateni-	24a. Was an 24 autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ▼No
25. Was case referred to medical	26. Place of Death (Che	k only one)	
examiner? 1  Yes 2  No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 📈 Nursing F	ome 5 Residence 6 D	Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work?  M 1 □ Yes 2 □ No	28d. Describe how injury occ	curred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Nu City or Town, State)	ımber or Rural Route Number,
29a. Certifier 1 Certifying Physic	cian: To the best of my knowledge, death occured at the time, date and place, a er: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause(s) and m	anner as stated. I due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Defense Huy, ANNAPOLIS MOZINOI

DHMH 17 Rev 7/2009

State Registrar MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stanford Collins Gaskins October 5:35 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) 1 🗙 M 2 🗆 Hours (Month, Day, Year) 02/17/1936 **Director** 75 578-48-8873 Kansas Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d, Inside City Limits Director Md. P.G. Upper Marlboro 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9717 Teakwood Drive 20774 U.S.A. or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? I Black, White, etc à 1 Never Married 2 Married Maryland 21215-0036 War If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Veterinarian/WRAMC U.S. Government Be permit. Page 1 and 2 should be filec.
Department of Health and Mental Hw.
Important: If item 27 is markany injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Gaskins Velveteen Edwards 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9717 Teakwood Dr., Upper Marlboro, Md. 20774 Rochelle T. Gaskins-Pinkard 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory, Inc. 20a, Method of Disposition 20c. Location - City or Town, State 10/2472011 1 Burial 2 X Cremation 3 Removal from State Beltsville, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final DISEASE Onset and Death Physician/ CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to in mediate cause. Enter Underlying Due to (or as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospita or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by ANOXIC ENCEPHALOPATHY Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC KIDNEY DISEASE Were autopsy findings available prior to completion of cause of death? 24a. Was an ANEMIA 1 Tes 2 L No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

State

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Muria Prantianer: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0/13/2011

29c. License number 00064986

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month (830 M TURD 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Days Hours 526-26-3130 81 **Director** 1 M 2 F Yrs 4/8/1930 New Mexico Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 931 Edgewood Road Apt 308 21403 USA ral", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental H tt: If item 27 Is marked ot y or other traumatic even မှ Walter Albert Reynolds Mary Ellen Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Carroll Drive, Annapolis, MD 21403 Donald Hurd - Son 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If itel any injury or oth 20c. Location - City or Town, State 1 Durial 2 T Cremation 3 Removal from State Baltimore Crematory 10/17/2011 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 977 000000 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death 5 Other (specify) detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy perform After this certificate I director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဝ 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred iniurv 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE 32. Registrar's Signature State OCT 17 2011 Registrar

**Division of Vital** State Registrar

Box 68760

P.O.

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahmanian, MD 1500 Forest Glen Road, Silver Spring, MD 20910

- CNICA

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1006657

29d. Date signed (Month, Day, Year)

October 8, 2011

Physicia /Medica Examine

**Funeral** 

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funarai Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

	For State of Maryland		iriment of Health a tificate of Death	riu ivi		g. No 2		34808
	Decedent's Name (First, Middle, Last)				2. Date of Deat	h		3. Time of Death
]	Patricia Anna Kokosk	co			October	12	2011	8:40 AM
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death			ity of Deat	
	Summit Park Health and Rehabilita					Ba1		
	5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 83  Usual Residence of Decedent	Yrs.	Months Days Hours	Min.	928	9. Birthplace (State or Foreign Country) Pennsylvania		
	10a. State 10b. County 10c. City, T	own or Lo	cation					10d. Inside City Limits
5	MD Baltimore		Catonsville					1 ☐ Yes 2 🙀 No
	10e. Street and Number		10f. Zip Code		1	0g. Citizen o	f What Co	untry?
5	1502 Frederick Road		21228			US		
y mileiai Dilecto	11. Marital Status  1 ▼ Never Married 2 Marned  1 ▼ Never Married 2 Marned  1 ↑ Yes, Give	+	Vas Decedent of Hispanic Original Yes, specify Cuban, Mexican,  Yes 2 No Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		lack, White	rican Indian, e, etc.
2	3 Widowed 4 Divorced Year or Dates:						Wh	ite
אוביבות	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupation kind of work done during most DO NOT use retired)	of workir	ng g	16b. Kind of	Business/	industry
	Elementary/Secondary (0-12) College (1-4or 5+)	_	stered Nurse			Group	Heal	th Insurance
	17. Father's Name (First, Middle, Last)			's Name	(First, Middle,			
2	George Kokosko		Mar	y			K	ordiak
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number	or Rura	l Route Number	City or Ton	m, State, 2	Zip Code)
ı	Margaret A. Rodgers-McKenna, nico		878 Bay Front					
	20a. Method of Disposition 1	e of Dispo: etery, cren	sition (Name of natory or other place)	D	ate	20c. Locatio	n - City or	Town, State
			eart Cemetery			Brisbi		
	21. Signature of Funeral Service Licensee  William R- M0071		Name and Address of Facility. Name and Address of Facility.					
	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.			ardiac o	r respiratory arr	est,		Approximate Interval Between
	disoaso of condition	EN	IA					Onset and Death
	resulting in death)  Due to (or as a consequent		-157					musum
	Sequentially list conditions, if any, leading to immediate						-	VIII CON A TOTAL
	cause. Enter Underlying Cause (Disease or injury							
	that initiated events c. Due to (or as a consequent con	ice of):						,
5	d							
	IF FEMALE:				MES			
	23b. Was decedent pregnant in the past 12 months?	ath 3 🗌	Ectopic pregnancy				Date of del Month	Day Year
	1 Yes 2 No 4 Pregnant at time of death	h 5∐	Other (specify)					
	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause given in Part I.		23e. Did to	pacco use co	ontribute to	the cause of death?
	DECEMENTAINE JUNE	20.8	GA3E		1 🗆 Y	s 2 No	3 🗆 Pf	obably 4 Onknown
					24a. Was a		b. Were au	utopsy findings available
					autops perfor	ńed?	death?	completion of cause of
2	25. Was case referred to medical examiner?		26. Place	of Death	Check only or			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Hospital*	/Outpatien	t 3□ DOA Cther: 4□ Nurs	sing Hon	ne 5□Reside	ence 6 🗆 🤇	other (Spe	cify)
	1 Natural 5 Pending (Month, Day Year)	b. Time of Injury	28c. Injury at Work?		28d. Describe h	w injury occ	urred	
	2 Accident investigation 3 Suicide 6 Could not be 780 Place of Injury At home	farm sto	M 1 Tyes 2 N		184 Leasting /S	sant and Mu	mbas as C	sal Bouto Number
	4 Homicide  4 Homicide  4 Homicide  4 See Place of Injury - At home building, etc. (Specify)	, rarm, stre	еет, тастогу, опісе	4	City or Tow		IIIDer or A	urai Route Number,
	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death	occurred at the time, date and restigation, in my opinion, death	place, a	and due to the c	ause(s) and ate and plac	manner as	s stated. e to the cause(s)
	29h. Sineature and title of certifier		29c. License number		2	9d. Date sig	ned (Mont	h, Day, Year)
	ATTENDING		D005696	18				2011
	30. Name and address of person who completed cause of death (Item 23	Ba) (Type. I						
à	JAMES AMOINDA 3455 W	الالا	Aares	204	RALI	IMON	- 1	10 2126
	31. Date filed (Month, Day, Year) 32. Registrar Signature	· k	1					
	OCT 18 2011 Denus	D.	La arke					

State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		- 1	= State RegistrarAMEND#26(a/b)+			artment of He			001	1 21.000
	Physicia	n/	1. Decedent's Name (First, Middle, Las Bernard Ku		MW,MOO	incate of De	,atri	2. Date of Dea	th er <sup>Day</sup> 28, 201	3. Time of Death 1 1045 PM <sub>M</sub>
	Medic Examin	al .	4a. Facility Name (if not institution, give			4b. City, Town, or Lo Bethesda	ocation of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. S		ast birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth Man ch h	9. Bi	rthplace (State or Foreign ountry) NY
٥	laryland 3a-f show iffied at	l h	Usual Residence of Decedent	_	y, Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	with the N 23a or 24 ust be no	Funeral Director	10e. Street and Number 12105 Little Cree	ek Drive		10f. Zip Code 20854			10g. Citizen of What C United S	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Department of Heath and Mental Hygiene.  The mortant: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.	1	Was Decedent of Hisp fYes, specify Cuban, I ☐ Yes 2 🛣 No	Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
215-0	in 72 hou e. nan "natu Medical	Completed by	15. Decedent's Elementary/Seconday (0-12)	rade completed)  College (1-4 or 5+)	(Give life. D	dent's Usual Occupati kind of work done dur O NOT use retired)	ring most of work		16b. Kind of Business Federal Go	
nd 21	filed withital Hygien tal Hygien ed other the event, the	To Be Co	17. Father's Name (First, Middle, Last) David Kulik	5+	Go	vernment I		e (First, Middle,	Maiden Surname)	JVETIMENC
<b>Naryla</b>	should be and Men is marke raumatic	-	19a. Informant's Name/Relationship (7				d Number or Rura	al Route Number	r, City or Town, State, Z	
Baltimore, Maryland 21215-0036	age 1 and 2 ant of Health It: If item 27 y or other t		Debra R. Kulik  20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	20h I	Place of Dispo	9 Stags Le psition (Name of matory or other place) morial Gardens		ace, Ge Date /2011	rmantown, l 20c. Location - City of Olney, MD	
Baltir	permit. P. Departme Importar any injur. once.	5	21. Signature of Funeral Service Licen		0 25	Name and Address	of Facility			MD 20852
3 F	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Hemorrhage Immediate Cause (Final									
	Medical	Medical disease or condition resulting in death) a. Due to (or as a consequence of):								
	Examiner		Consideration for a section	Due to (or as a conseq Rupture Rustu	uence of):					days -Minutes
		caminer	Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a conseq	uence of): ed					
		dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Ruprtur	uence of): ed					
		dical	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a conseq	quence of):  cl Cer quence of): quence of): quence of): ancy tal death 3 [	ebral Ves	sel		23d. Date of o	Minutes
P.O. Box 68760		Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a consequence of	ancy tal death 5 [	Ectopic pregnancy	sel	23e. Did t	Month obacco use contribute	Minutes
P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial target.	Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or as a consequence of	ancy tal death 5 [	Ectopic pregnancy	sel	23e. Did t 1 □ 24a. Was auto perfc	Month  obacco use contribute  Yes 2 X No 3   an	delivery Day Year  to the cause of death?  Probably 4 □ Unknown autopsy findings available to completion of cause of
P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial target.	Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of	quence of):  ancy tal death 3 [ death 5 [ death 5 [	Ectopic pregnancy Other (specify) underlying cause give	se1 en in Part I.	23e. Did t  1 □  24a. Was auto perfo 1 □ Yes ck only one)	Month  obacco use contribute  Yes 2 X No 3   an	delivery Day Year  to the cause of death?  Probably 4 □ Unknown autopsy findings available to completion of cause of ? Yes 2 □ No
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ivision of Vital Records, P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial target.	Certificate: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consequence of	ancy tal death 3 death 5 ER/Outpatie 28b. Time cinjury	Ectopic pregnancy Other (specify)  underlying cause give  26. Placent 3 DOA Other  28c. Injury work? M 1 DOA	se1  on in Part I.  ce of Death (Checker 4  Nursing Heat	23e. Did t 1	Month  obacco use contribute  Yes 2 X No 3   an	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available to completion of cause of? Yes 2 No
ivision of Vital Records, P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial target.	Certificate: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consequence of the contribution of the best of my known of the contributions of the best of my known on the be	ancy tal death 3 death 5 [  ER/Outpatie 28b. Time c injury  Inome, farm, st  Wiedge, death on and/or inventored in the control of the control	Ectopic pregnancy Other (specify)  underlying cause give  26. Platent 3 DOA Other  28c. Injury ork? M 28c. Injury ork? The control of the con	se1  ce of Death (Chec  4  Nursing H  at  ofes 2  No	23e. Did t  1	Month  obacco use contribute  Yes 2 No 3   an 24b. Were prior to death 2 No 1   dence 6 Other (Sp. now injury occurred)  Street and Number or iwn, State)	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available to completion of cause of? Yes 2 No  Rural Route Number, stated. he cause(s) and manner stated
ivision of Vital Records, P.O. Box 68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial target.	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consequence of the consequence of t	ancy tal death 3 death 5 [  ER/Outpatie 28b. Time c injury  Inome, farm, st  Wiedge, death on and/or inventored in the control of the control	Ectopic pregnancy Other (specify)  underlying cause give  26. Platent 3 DOA Other  28c. Injury. work? M 28c. Injury. work? The coccured at the time, stigation, in my opinior death occurred at the 29c. License	se1  ce of Death (Check 4 Nursing H at yes 2 No  date and place, a n, death occurred a time, date and pla number	23e. Did t  1	Month  obacco use contribute  Yes 2 No 3   an 24b. Were prior to death 2 No 1   dence 6 Other (Sp. now injury occurred)  Street and Number or iwn, State)	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available to completion of cause of? Yes 2 No  No  Necify)  Rural Route Number,  stated. The cause(s) and manner stated as stated.  In this pay, Year)
ivision of Vital Records, P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial target.	Certificate: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of the consequence of t	ancy tall death 3 [death 5 [sultting in the last lingury] and the last lingury and the last lingury] and the last lingury and last linguist linguis	Ectopic pregnancy Other (specify)  underlying cause give  26. Place to the state of	se1  ce of Death (Check 4 Nursing H at At Ates 2 No  date and place, a n, death occurred a time, date and pla number	23e. Did t  1	Month  obacco use contribute Yes 2 X No 3   an	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available to completion of cause of? Yes 2 No  Rural Route Number,  stated. ne cause(s) and manner stated as stated. inth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20 Î Î 18 04:45 A M Medical Edith S. Kale 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Montgomery Hospice Casey House Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🖾 F Months Davs Hours Min March Day 2 1, 1929 Director 82 172-22-8735 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amount injury or other traumatic event, the <u>Medical Examiner must be notified as once.</u> 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15115 Interlachen Drive #917 20906 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black. White, etc Completed by 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medica1 4 Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rose Saletsky Max Belmont 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15115 Interlachen Drive #917, Silver Spring 20906 19a. Informant's Name/Relationship (Type, Print) David L. Kale/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Adelphi, Maryland Mt. Lebanon Cemetery 10/11/2011 22. Name and Address of Laward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licenses Moisar maquentar 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ Theumonic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-pressit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 month Day Year Pregnant at time of death Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an has performed: prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is 1 Tyes 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) P 1 🗌 Yes 2 🕱 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPKO Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical \*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar 29d, Date signed (Month, Day, Year) D37142 10-10-2011

State

Registrar

30. Name and add

M.D.

20850

1355 Piccard Drive Suite 100, Rockville, MD

ess of person who completed cause of death (Item 23a) (Type, Print)

Coleman.

2. Registrar's Signature

MIT

13 2011

11-07514 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Leonard Lonigan State of Maryland / Department of Health and Mental Hygiene 1- For State AVEND#28 per ME. Registrar 1 0/17/2011 AACO HEALTH DEPT. OF tifficate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 7, 2011 Medical Examiner 0631 hrs John Leonard Lonigan 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Rt. 258 and Nutwell Sudley Road Deale Anne Arundel 5 Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min Country) DC 1 X M 2 F Yrs 220-29-5263 20 12/11/1990 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Anne Arundel Dunkirk s I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", nr items 23s nr 28s-f sho Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 293 Southland Court 20754 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, the Medical Examiner must be 1 X Never Married Armed Forces? If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 2 Married 2 X No Yes White 4 Divorced f Yes, Give Year 1 Yes 2 No specify: Specify: <u>გ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore**, MD 21215-0036 12 Local # 5 Iron Worker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Harry George Lonigan Karen Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen H. Klayman Mother 293 Southland Court Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Atlantic Crematory 10/11/2011 Glen Burnie, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home P.A.Annapolis, MD 21401 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical g physician a the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth led by the attending detached for use as 1 3 Ectopic pregnancy for use as Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 V Other: Scene 2 ER/Outpatient 3 DOA 1 ✓ Yes 2 No 28d. Describe how injury occurred Driver in Diver in auto-auto collision Auto Auto Collisi 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? To the Funeral Director: A 1 Natural Oct 7, 2011 Pending 1 Yes 2 V No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Rt. 258 and Nutwell Sudley Road, Deale, MD determined (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. d October 8, 2011 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State anks Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Bernice Lashlev October 0 08:00 A<sup>M</sup> Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NMS Healthcare of Hagerstown Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days 1 M 2 XF 04/13/192 90 Director <u> 220-18-1077</u> MD Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14014 Marsh Pike 21742 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force \$ 1 Never Married 2 Married Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4 or 5+) Elementary/Second 12th onday (0-12) Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Leroy Francis Mose Edna Lena Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health s item 27 i Jefferson St., Hagerstown, MD 21740 <u>Virginia L. Hartman /</u> Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/19/2011 | Hagerstown, MD Rose Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 North Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner End Stage Dementia Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a gunsecuence of Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 XNo Ectopic pregnancy Pregnant at time of death ed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b S Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 😿 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death. To the Funeral Director; Aft completed filled in by the fun ...atural ☐ Accident ☐ Suic Investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier DIRENTILL CRUP R125748 October 16, 2011 Johanu mer 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Comer-Concordia CRNP 14014 Marsh Pike, Hagerstown, MD 21742 31. Date filed (Month, Day, Year State OCT 18 Registrar

11-07991 Phillip Lyons

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificate of		wichtai riygi	Reg	No.	1 0401
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)		·		Date of Death		3. Time of Death
Heultai Exami	mer	Philip Morris Lyons  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc		Month [ October 24,	2011 4c. County of Death	0149 hrs
		Dorchester General Hospital		Cambridge	Cattory or Death		Dorchester	
Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs. 8	. Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		215-98-7611 1KM 2_F	38 <sub>YI</sub>	Months Days	Hours Min.	June 14	, 1973 Foreig	n untryMaryland
any any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ation				404 1-11-05-11-1-
		MD Dorchester	Toc. City, Town of Loca		ridge			10d. Inside City Limits  1 Yes 2 K No
aryland  Ba-f show	Director	10e. Street and Number		10f. Zip Code		10a	. Citizen of What Cour	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked ather than "natural", ar items 23a nr 28a-f she or other traumatic event, the Medical Examiner must be notified at once		5328 Bucktown Road			21613		USA	•
ath wit fems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If	/as Decedent of Hispar Yes, specify Cuban, M	nic Origin? ( Specif lexican, Puerto Rica	y Yes or No- an, etc.)	14. Race - Americ White, etc.	can Indian, Black,
her de		3 Widowed 4 Divorced If Yes, Give Year	X No	Yes 2 No s	pecify:		wh Specify:	ite
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Baltimore, Mi bernit. Pages 1 and 2 s Department of Health a Important: If item 27 njury or other traum		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from Sta	crematory or o				20c. Location - City or	
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Baltimore permit. Pages 1 Department of H Important: If i		21 Signature of Funeral Service Licensee	4.0	Name and Address of OO Locust S	111011		eral Home	P.A.
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/Medical .ixaminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic a	and Cocaine	Intoxicat	ion			Between Onset and Death
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Division of Vi To the Hospital nr Attending Physi within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	(Check only one) Wedical Examiner: On the basis of exam						
<b>1</b>	¥ €	29b Signature and title of certifier		29c. License nu	ımber	2	9d. Date signed (Mon	th, Day, Year)
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		Name and address of person who completed cause of de		alkimana Otroni. T	Dalkins as A47 :	04000		
	ate	Laron Locke MD. Assistant Medical Exal  31. Date filed (Month, Day, Year)  32. Registrar			paitimore, MD 2	21223		
Regist	rar	OCT 27 2011 Comme	s Signature			_		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 10 Physician/ Glenn H. Lahman October 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 88 East Street Annapolis Anne Arundel 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Sex Age (In vrs. last birthday) **Funeral** 1**x** M 2 □ F Months Days Hours Olfredtry) 309-22-9003 86 1271471924 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medi-al Examiner must be notified at any injury or context and any injury or other traumatic event, the Medi-al Examiner must be notified at any injury or other traumatic event, the Medi-al Examiner must be notified at any injury or other traumatic event, the Medi-al Examiner must be notified at any injury or other traumatic event, the Medi-al Examiner must be notified at any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA Funeral 88 East Street 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 XMarried þ 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced WWII Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Radio & TV Engineer Broadcasting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cloden Jonas David Lahman Hilda Elizabeth Fauser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Lahman - Daughter 4603 Owensville Sudley Rd, Harwood, MD 20776 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Baltimore Crematory 1 Burial 2 TCremation 3 Removal from State 10/13/11 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Mych 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ostal disease or condition Medical resulting in death) 2008 **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of); attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? signed by the a Yes 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an eral Director: After this certificate has filled in by the funeral director, page 2: performed? Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manual of Death Certificate: 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a
To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nursa Practioner: To the best of my knowledge, death occursed at the fline, date and other in this relievels) and memorials state 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D E 6818 2011

State Registrar Annapolis, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arun Bhandari

31. Date filed (Month, Day, Year)

129 Lubrano Drive #201

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 20, Oct. Richard 1213 p.<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 49 S. Colonial Drive Hagerstown Washington Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Hours Min. Director 82 Feb. Maryland 218-24-1348 Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 514 E. Franklin Street 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🔀 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Engine</u> Line Truck Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Kenneth McCarney Mary Gertrude Everly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Corbett - Daughter Fairground Avenue, Hagerstown, Md. 21740 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lawn Mem. Park 10/25/2011 Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final naet and Deat Physician/ disease or condition Medical resulting in death) **Examiner** 16916 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal Good ☐ Pregnant at time of death ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably 4 Unknown FIBRICATION 24a. Was an 24b. Were autopsy findings available Jas prior to completion of cause of death? 2 🗀 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred latural 5 Pending injury work? 1 ☐ Yes 2 ☐ No thin 24 hours after death. the Funeral Director: After management of the function of the func 2 Accident 3 Suicide 4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

**Division of Vital** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	uneral irector		577-26-3083	1 XM 2 □ F =	ge (In yrs. last birthda 87 88 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 08/13/		9. Birthpl County	ace (State or VY	Foreign
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Baltimore, bermit. Page 1 and Department of Hea	If iten or oth		20a. Method of Disposition 1   Burial 2 ☐ Cremati	ion 3  Removal from State	cemetery, o	sposition (Name of crematory or other place		Date	20c. Location	-		
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			shock of heart failure. Li	, or complications that cause ist only one cause on each lin	d the death. Do not e.	enter the mode of dyin	ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Betw	een
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<b>6876</b> Sertificate	e as th	Med	IF FEMALE:						- 1			
Box 6	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal death	3  Ectopic pregnand 5  Other (specify)	су			te of deliver		ear
D. Be	ached	hysi	1 Yes 2 No 9 Unknown	9 🗆 Unknown	- douti	o 🗆 Other (specify) _						
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DIVISION Of VITAI RECORDS, tal or Attending Physician: The law requires rs after death.	e has l	Completed by						24a. Was autoj perfo 1  Yes	osy	prior to com death?	sy findings av pletion of car	use of
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DIVISION OF VITAI RECC To the Hospital or Attending Physician: The law within 24 hours after death.	e Fune	Medical	(Check 2 \(\sumeq\) Medica	ring Physician: To the best of al Examiner: On the basis of e ring Nurse Practitioner: To th	xamination and/or in	vestigation, in my opinio	on, death occurred a	it the time, date a	nd place, and due	e to the caus	se(s) and manr	ner stated.
To th withir	₽ OF SE		29b. Signature and title of certi		,	29c. License			29d. Date signed			
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-			30. Name and address of personal Susan J. Mil	on who completed cause of d ler 8218 Wisc			ethesda l	MD 2081	4	•		
R	Stat Registra	_	31. Date filed (Month, Day, Year OCT 13	2011 Lentus	ar's Signature	wed.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Lue Marlow 6:38 am October 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Burtonsville Sanctuary at Holy Cross Nursing Home Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Pay Year) 933 1 M 2 X F Min West Virginia Director 235-50-1042 Usual Residence of Decedent 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Berkeley Martinsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 226 Caledonia Drive 25405 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Samuel J. Grass Rushie Lanham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Myers - Daughter 15310 Blackburn Road, Burtonsville, Maryland 20866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 10/14/2011 Brentwood, Maryland 22. Name and Address of FacilityHines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee M01564 nguson 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complice in s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COMEOL. 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Dun to for est a nonsequer ne of that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 2 [] M6 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by to the Hospital or Attending Physician: The law requires talking 24 hours after death.
To the Funeral Director: After this received on the Funeral Director. 1 Tes 2 No 3 Probably 4 tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manual of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 2 D0069820 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TENSEEN R Nagyli', 2835 Smith Suite 203-B, State

DHMH 17 Rev 7/2009

Registrar

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34819

Physician/
Medical
Examiner

**Funeral** 

Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036 Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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oietea linea in by the furteral director, page z snoula be detached	ical	29a. Certifier 1	Certifying	Physician: To	o the best of	my knowle	edge, death	occured at	the time,	date and	place, an	d due to the ca	ause(s) a	ınd manne	r as state	d.	
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 5 per FD, DOR, 10/25/11, LDB State of Maryland / Department of Health and Mental Hygiene

1 - For Amend 10a per FD, DOR,
Registrar 10/18/11, LDB Certificate of Death
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day Physician Mc Donner Elizabeth /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner William Hill Easton If Under 1 Year | If Under 24 Hrs. Marrox albot Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 188<sup>1</sup>2<sup>1</sup>8572 Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🗗 F Months Days Hours Min. 95 Director 1916 mD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Funeral Director 1 Her 2 □ No St. Lucie 10e. Street and Number 10g. Citizen of What Country? Morningside Blv

12. Was Decedent Ever in U.S.
Armed Forces?

1 \( \text{Yes} \) 2 \( \text{No} \) 4952 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married , o. Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: If Yes, Give Year or Dates: <u>م</u> 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 nomemaker OUM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ant of Health and Mental Hit: If item 27 is marked oth y or other traumatic even Elizabeth Stroud ၀ Trice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester River D presenville, md 21638 Department of Heal Important: if item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State re Cremation 10-17-2011 Cambridge MD 22. Name and Address of Facility Mid Share Cremenian Educar By 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee College Curren-Bromuse 1, P.A. Cumbridge, mp 21615 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1EAL **Physician** END-STAGE CHROWIL DESYRLCTIVE VULMONACY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ATRIAL FIBRILLATION, CONGESTIVE IBART FAILURE 1 XYes 2 No 3 Probably 4 Unknown HYPLETELSION, CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospitai TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 160 E 500 T TTENDINGMID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD321 BLOOMINGDALLA 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ William Devlin McCartan 4:45 Рм October 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5802 63rd Place Riverdale Prince George's 8. Date of Birth 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Min 1 M 2 D F 123-32-1024 Yrs. 1941 Manhattan, New York Director 70 August Usual Residence of Decedent show I Hygiene. other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🛛 Yes 2 🗌 No Riverdale Prince George's Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 5802 63rd Place USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian rmed Fo Black, White, etc. 1 Never Married 2 Married þ 2 No Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates. VIETNAM 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University of Maryland Electrician 12 event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည be Edward McCartan Margaret Devlin permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. McCartan / Wife 5802 63rd Place, Riverdale, MD 20737 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/21/2011 George Washington Cemetery Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Esophageal Cancer Year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Examir burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Attending Physician: The law page 2 has performed? Yes 2 No certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. 2 Accident
3 Suícide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) ò Hospital Medical 29a, Certifie 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10/18/2011 D54378

Registrar

DHMH 17 Rev 7/2009

State

1+1

Cheryl Aylesworth, M.D., 2730 University Blvd., #400, Wheaton, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 1 9 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year DYROA Wunamaker OFF WINE. 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** and Health C are Center Harrenstow N washing-ton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. (Month, Day, Year) 81 Maryland Director 220-26-5204 Dec Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland 1 X Yes 2 □ No Washington Hagerstown 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be n Funeral 333 Mill Street 21740 U.S.A. items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ö ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Baker Ethe1 Grace Reeder and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Gary L. Nunamaker/son 4914 Harpers Ferry Road Sharpsburg, Maryland 21782 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Benevola Church Cem. | 10/23/2011 Boonsboro, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 21. Signature of Funeral 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ 100 Car leant Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-transit Dertenson and that initiated events resulting in death) Last Die o (or as a consequence of): anding physician are as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. French After this certificate has been signed by the attending physicis. P.O. Box 68760 es, outcome of pregnancy
Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No ō Month Dav Year Pregnant at time of death 5 Other (specify) detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? yophagio 24a Was an Di Sease, L After this certificate has funeral director, page 2: autopsy performed 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-3 Mill Street 33 Maden-Blucker

DHMH 17 Rev 7/2009

State Registrar 32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 17. 201<sup>Yea</sup> WILLARD H. NORTHAM 1320hrs.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hartley Hall Nursing and Rehab Center Pocomoke City Worcester Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 X M 2 □ F Hours 04/09/19<sup>(Month, Day, Year)</sup> Virginia Director 92 219-01-3296 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Market Street 21851 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 2 No 44- 46 ģ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Life Insurance Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nell Bloxom Mulford Northam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Lee/ daughter 20 Buck Harbor Court, Pocomoke City, MD 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ∤ranklin City Cem. 10/21/2011 Stockton, MD 21 Signature of Fundal Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A., 107 Vine Street, Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Medical resulting in death) Due to (or as a conseque ce of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' After this certificate funeral director, pag Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and on investigation, it may open an added and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

3+12+1

State Registrar 31. Date filed (Month, Day, Year) 18 2011

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

Ket

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylar				/lental Hy	2011	34824
			Registrar	Cer	tificate of D	eatn	0.01.10	Reg. No. CUII	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Nichael 5	OBRI			2. Date of De Month	Day Year	3. Time of Death
	Medic	al	·	OURI			10	20 2011	10:30AM
	Examin	er	4a. Facility Name (if not institution, give street and number) Twita Manor Health CareCr	0 170	4b. City, Town, or I			4c. County of Deat	
			5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		thplace (State or Foreign
	Funeral Director		219-74-8300 1 X M 2 🗆 F 52		Months Days	Hours Min.	(Month, Da	v. Year) Co.	untry)
10			Usual Residence of Decedent				ADLIL 2	1939   Ma	iryrand
	and shov	힏	10a. State 10b. County 10c. Ci	ity, Town or Loc	ation				10d. Inside City Limits
	Aaryl 8a-f tified	rect	MD Washington Ha	agersto	wn				1 ¥ Yes 2 □ No
	the h		10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?
	with s 232 ust k	era	342 Vista St.		21740	0		U.S.A	•
	item item	Fur	11. Marital Status 12. Was Decedent Ever in U.	.S. 13. V	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Spanic Origin?)	ecify Yes or No-		
90	fter (	by	1 X Never Married 2 ☐ Married  Armed Forces?  1 ☐ Yes 2 X No  If Yes, Give		☐ Yes 2 X No			Black, White Specify: 1,11	
ö	ours a tural al Ex	Completed by Funeral Director	3 Wildowed 4 Divorced Year or Dates.					VVI.	nite
<del>7</del>	72 hc 1 "na ledic	ıβle	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupa and of work done du	ition uring most of work	ing	16b. Kind of Business	Industry
4	thin ane. thar he M	Son	Elementary/Seconday (0-12) College (1-4 or 5+)		ONOT use retired) er Worked			N/A	
η σ	ed wi Hygid Sther	Be (	17. Father's Name (First, Middle, Last)				e (First Middle	Maiden Surname)	
an	be fill ental ked c	인	James Henry O'Brian			Susan E.		mared armano,	
Ž	ould Me mar		19a. Informant's Name/Relationship (Type, Print)	19h Mailin	n Address (Street a			er, City or Town, State, Zij	n Code)
Š	2 sh Ith ar 27 is 27 is	- 3	Carmen S. Bundick/WCHDC	1	Brewer Av				
ē,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of		Date	20c. Location - City or	Town, State
JO L	age ant of ant. If it		I Dullai 2 44 Ciciliation 3 D Nemoval nom State		natory or other place		2/2011	Smithsburg	~ MD
Baltimore, Maryland 21215-0036	artm. Portar ortar injur		21. Signature of Funeral Service Licensee					en Funeral (	
B	Dep Imp any onc	7	> SMent Suns					agerstown, l	_
			23a. Part 1. Enter the disease, or complications that caused the dear						Approximate
dir tag	Ph_sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0.	LA:	C 11	1		Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (or as a consequence)	quence of):	somolii	of The	Livers		
	Examiner		Ptpin ( E.)		timal				
	- 1	ner	if any, leading to immediate Due to (or as a conseq		1				
	uted d ansit	ami	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  C. Due to (or as a conseq	Di50	-der				
	exection and ial-tra	Ĕ	resulting in death) Last  Due to (or as a conseq	quence of):					
09	ate be executed physician and the burial-transit	dical Examiner	d. Hyperter	noisel					
876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE:						
Box 687	aath certifica attending p I for use as 1	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregna		Ectopic pregnancy	/		23d. Date of de	
Bo	deatl	sici	in the past 12 months?  1 ☐ Yes 2 ☐ No  2 ☐ Unknown  9 ☐ Unknown	death 5	Other (specify)			Month	Day Year
o ·	t the by th	Physician/Me	9 🗆 ONKNOWN	10		- 1. D-11			
Records, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not res	suiting in the u	nderlying cause give	en in Part i.		obacco use contribute to	
Sp.	equire sen si ould	ted	Menitar Retardation				1 🗆	Yes 2 □ No 3 □ P	robably 4 🔼 Unknown
00	has be je 2 sh	ıple					24a. Was auto	psy prior to	itopsy findings available completion of cause of
Re	Physician: The lav If this certificate has If director, page 2	Completed by						ormed? death?	s 2 🗆 No
g	sian: ertific ictor,	Be	25. Was case referred to medical examiner?			ce of Death (Chec	k only one)		
>	hysic his o	우	1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐		t 3 DOA Other	r: 4 🔀 Nursing H	ome 5 🗆 Resi	dence 6 Other (Spec	cify)
0	ing P	ate:	27. Manner of Death  28a. Date of injury  1   Natural 5 □ Pending (Month, Day, Year)	28b. Time of injury	28c. Injury work?	?	28d. Describe	how injury occurred	
<u>o</u>	tend leath tor: /	ific	2 Accident Investigation 3 Suicide 6 Could not be	<u> </u>		Yes 2 □ No			
Division of Vital	I or Attend after death Director: A I in by the f	Certificate:	4 Homicide determined 28e. Place of Injury - At h. building, etc. (Specif.		et, factory, office		City or To	Street and Number or Ru wn, State)	irai Houte Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completed filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my know	uladaa daath s	socured at the time	data and place as	nd due to the o	gues(s) and manner as et	ated
	Hos 24 hc Fun eted	Medical	(Check 2 Medical Examiner: On the basis of examination	on and/or invest	igation, in my opinior	n, death occurred a	t the time, date	and place, and due to the	cause(s) and manner stated.
	o the	Σ	only one) 3 Certifying Nurse Practioner: To the best of m 29b. Signature and title of certifier	ny knowledge, c	29c. License		ce, and due to ti	29d. Date signed (Mont	
	FSFO		Ball as Drade Blade	CRAID	R125			10/20/2011	
	The same of the sa		30. Name and address of person who completed cause of death (Iter	m 23a) (Time E	rint)				
	14		Broken Nader-Plusto- Cl	2 N/D - 3	533 Mill	Street.	Harp.	restown, Mi	021740
	Stat	e	31. Date filed (Month, Day Year) 32. Jegistrar's Signa		201		-10		
	Registra		OCT 2 2 2011 Busin	B. A.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Nacia Ctobec 6 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year OCT 30, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F DC 81 040-24-7407 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show notified at 10a State 1 ☐ Yes 2X No Director Germantown MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be 20874 United States 13104 Shadyside Lane Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 24 If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: ģ Caucasian 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed withir Hygiene. Bookkeeper Mariott 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hyg important: If item 27 is marken any injury or "". 17. Father's Name (First, Middle, Last) Be Ryder Foss Joseph Michael Mancuso Haze1 ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13104 Shadyside Lane, Germantown, MD 20874 Anthony Ontko/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 10/15/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a.
7 Park Avenue, Gaithersburg, MD 20877 M00956 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final troke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Live birth 2 Fetal death Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 2 No 1 ☐ Yes 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 5 Pending investigation (Month, Day Year) the Hospital or Attending 1 Natural Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 6,2011 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001 11595

State

Registrar

4940 Eastern Avenue, Baltimore, MD, 21224

Chai

32. Registrar's Signature

Cindly

13 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Amelia Jackson Peoples 2011 11:20 P. M October 9 Medical Facility Name (if not institution, give street and number)
Forestville Health and Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Forestville Rehabilitation Center Yeal 921 1 Year If Under 24 Hrs Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Months Hours. Min (Month, Day, 207-14-9450 90 Director August South Carolina Usual Residence of Decedent ь пэ шагкед other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1X Yes 2 □ No Prince Georges Maryland Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1408 Barnacle Geese Court 20774 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Ecarrone. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Black ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC 8th grade Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eddie Jackson Rosa Bell Wilder 19a. Informant's Name/Relationship (Type, Print) 20774 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Peoples Smith (Daughter) 1408 Barnacle Geese Court; Upper Marlboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 15,2011 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Suitland, Maryland Lincoln Memorial Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner PER でしいしつ Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on: ISEASE ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 2 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 5 Pending Accident
Suicide 1 🗌 Yes 2 No Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

1AHBOOK

0070693

Annapolis, Maryland

29d. Date signed (Month, Day, Year)

14, 2011

October 0

21401

2007 Tidewater Colony Drive; Suite 1A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2011 9:17 Hubert Reeder Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Washington 351 East Ridge Drive 21740 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 23, 1929 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Hours 1 X M 2 - F Days Mary Land Director 216-30-3289 82 Usual Residence of Decedent ims 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 351 East Ridge Drive 21740 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any fijury or other traumatic event, the Medicial Examiner. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No 1947-Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🛛 Widowed 4 🗆 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Field Services Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Amos Reeder Margie A. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki S. Jagodowski/daughter 3499 Pebble Beach Road Lakeville, New York 14480 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 10/20/2011 Frederick, Maryland 21. Sign ture of Funer U.S. w.c., Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 Inter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on such chairs. shock Interval Between Immediate Cause (Final Onset and Death Physician ancreas disease or condition resulting in death) Medical Die to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician. The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): anding physician are as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death Unknown , the & 9 Unknown detach been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death.

I Director: Af in by the fu 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 Signature and title of ce 29d. Date signed (Month, Day, Year) MD 2011 102057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19, 2011 1 10115 AM **Physician** Leila Virginia Robinson October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Medical Lab Washington Hagerstown 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs.

9 5 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9-8-1916 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex **Funeral** 215-42-4161 1 □ M 2 🛛 F 95 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic sysut, the Medical Examiner must be notified at MD Washington Hagerstown 1 XYes 2 No Director 10e. Street and Number 310 Cameo 10f. Zip Code 21740 10g. Citizen of What Country? or itsms 23a or Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: If Yes, Give Year or Dates: 3

Widowed 4 □ Divorced naturai 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) residence e filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker 8th grade 0 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked other any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surmame)
Alice Everetts William L. Hull 19a. Informant's Name/Relationship (Type, Print)
Russell Robinson 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Vineyard Rd. Falling Waters, WV 25419 son 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul Cemetery 20a. Method of Disposition 20c. Location - City or Town, State  $10 - 2^{10} - 2^{-10}$ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD 2011 21. Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> Thompson Funeral Home, Inc allin P.O.BOX 310 Clear Spring, MD 21722 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Candice Anner few min /Medical Due to (or as a consequence of): Examiner Severe Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last سرو Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Mellity page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? HAR MEDIENL LAB 26. Place of Death | Check only one 1 Yes 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ospital.
4 hours after dea.....real Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation м 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours at To the Funeral D completely filled it

State Registrar

Medicai

Chark willy one)

29b. Signature and title of certifier

at mo

October 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 346 MILLST HAGERSTOWN MD 21740 ASAUT mb 31. Date filed (Month, Day, Year)

OCT 2 1 2011 32. Régistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0018019

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of F tificate of		Re	g. No. 🤈 🧎	34829
п	Physicia		1. Decedent's Name (First, Middle, Last) Norma Jean Rice					2. Date of Death  10-16-2		3. Time of Death 6:45 P M
1	/Medic Examin		4a. Facility Name (If not institution, give s 700 Green Street	street and number)		4b. City, Town, o	r Location of De le Grace	ath	4c. County of Dea Harfor	d
	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age	(In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		9. Bir	rthplace (State or Foreign ornfro) UGLNIA
	ryland show	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	h the Ma r 28a-f s	irecto	Maryland Harford  10e. Street and Number		Havre de	10f. Zip Code		10	g. Citizen of What C	
	death wit ms 23a c	neral D	700 Green Stree	12. Was Decedent B	Ever in U.S. 13.	21078 Was Decedent of I	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
980	ours after ral", or ite Erozvina	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Jo l	1 □Yes 2 X No			Specify:	White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the firedical Evertical roust or matths of once.	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (174or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of v d)		6b. Kind of Business Healthcar	
Maryland 2	and 2 should be filed within 7 ealth and Mental Hygiene. n 27 is marked other than " ier traumatic event, the Mec	To Be Co	17. Father's Name (First, Middle, Last) Ulise Cole				Betty J	lame (First, Middle, M Iean Keen		
Mary	1 and 2 shou Health and N tem 27 is ma		19a. Informant's Name/Relationship (Ty Robert E. Rice (hu					Rural Route Number, The de Grac		
a)	Pages 1 a lent of He nt; If item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, crei Harford M	osition (Name of matory or other pla emorual	Ĝdns 10-	Date -21-2011 AL	perdeen, N	r Town, State Naryland
Balti	permit. Pages 1 Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licens	Sulma	2:	2. Name and Addr 23 South	ess of Facility Z Washing	ellman Fun gton St, Ho	ieral Home avre de Gr	., P.A. 21078 Lace, Marylan
	Physician /Medical		art 1. Enter the disease, o compl shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	D) (fus	the death. Do not enne.  Class Ce a consequence of):	ter the mode of dy	ing, such as care	diac or respiratory arre	est,	Approximate Interval Between Onset and Death 22 menths
	Examiner =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):					
,092	ate be execute nysician and he burial-trans	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):					1
O. Box 68	Physician; The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transif	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death 3	☐ Ectopic pregnar ☐ Other (specify)	су		23d. Date of d Month	delivery Day Year
ds, P.	ires that isigned by	by Ph	Part II. Other significant conditions co	4	* 6	underlying cause g	iven in Part I.	23e. Did tob	17 A	to the cause of death?  Probably 4  Unknown
Records,	ding Physician; The law requinn. After this certificate has been sfuneral director, page 2 should	npletec	NIDOM			,		24a. Was a	sy priort	autopsy findings available o completion of cause of
tal F	an: The rtificate I tor, page	Be Con	Hypothycoldish 25. Was case referred to medical				26. Place of	perform 1 ☐ Yes 2 Death (Check only on	2 <b>X</b> No 1□Y	
of V	Physici this cer al direc		T Yes 2/500		ent 2 ER/Outpatie	III 3 LI DOA		ng Home 5 Reside	ence 6 Other (S	pecify)
ion	ng (fter	ation	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ny, Year) Injury	Wo	ork? □Yes 2□No	200. Describe the	on injury occurred	
Division of Vital		Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	iury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	dical (	29a. Certifier (Check only one) 2 Medical Exam	vsician: To the best iner: On the basis of and manner st	of my knowledge, dea of examination and/or i tated.	th occurred at the nvestigation, in my	time, date and p opinion, death	place, and due to the o occurred at the time, d	cause(s) and manner date and place, and c	as stated.  due to the cause(s)
	To th Withii To th	Me	29b. Signature and title of certifier  Product Shult	no		29c. Licer	nse number 00450	2	29d. Date signed (Mo	
			30. Name and address of person who co	ompleted cause of a	death (Item 23a) (Type	CS+. #4	ou Abe	rdeen mo	21001	
	St	ate	31. Date filed (Month, Dec.) (eat)		rar's Signature					

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	ryland / De	partment of	Health	and M	1ental Hy	giene		
			State Registrar		С	ertificate o	f Death			Reg. No. 🤈 🌘	1.1.1	31,830
н	Physicia	m/	1. Decedent's Name (First, Middle, I	.ast)					2. Date of De Month		Vear	3. Time of Death
Ļ,	Medic		Norman Lee Sm	allwood					Oct.	12, 20	11	0233 M
and the same	Examir	er	4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town		of Death			y of Death	
***	· · ·		1024 Boom Ct.  5. Social Security Number 6	Sex 7. Age	(In yrs. last birthda	Annap		24 Hrs	8. Date of Bir		e Aru	nde L
	Funeral Director		577-44-5468	1 <b>X</b> M 2 □ F	77 <sub>Yrs.</sub>	Months Day		Min.	(Month, Da	ıy, Year)	Count	try)
	4		Usual Residence of Decedent						01/09	/1934	<u> </u>	DC
	yland f sho ed at	Director	10a. State 10b. County		10c. City, Town or						1	0d. Inside City Limits
	Mar 28a- notifi	ire	MD Anne A	rundel	Annapo1							1 Yes 2 Xlo
	ith the	a	10e. Street and Number			10f. Zip Cod				10g. Citizen of		itry?
	ath w	Funeral	1024 Boom Ct.	12. Was Decedent Ev	erin IIS 1	2140 3. Was Decedent o		gin2 (Spe	cify Yes or No-	US	ce - Americ	an Indian
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 【X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cu	ıban, Mexicar	i, Puerto I	Rican, etc.)	Bla	ce - Americ ack, White, e y: Whi	etc.
5-0	"natu	Completed	15. Decedent's (Specify only highest			edent's Usual Occ e kind of work dor		t of workin	na	16b. Kind of E	Business/Inc	dustry
121	iled within 72 Il Hygiene. other than '	mo.	Elementary/Secondary (0-12)	College (1-4 or 5+	) life.	DO NOT use retire t Metal	ed)			Fadama	1 (	
5	filed wit al Hygie d other event, th	മ	17. Father's Name (First, Middle, Las	<u>Z</u>	Silee	t Metal			/Eirot Middle	Maiden Surnam		ernment
an	be filk ental ked c	일	Earl Smallwood	4					cGhee	iviaideri Surriari	<i>ie)</i>	
ary	should be file and Mental h 7 is marked o raumatic eve		19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stre				er. Citv or Town.	State. Zip C	Code)
	d 2 sk alth a n 27 is		Wilma Smallwood	(spouse)	1171	4 Boom C					, 1	,
ore,	of He fiter		20a. Method of Disposition	Demonstration State	20b. Place of Dis	position (Name of ematory or other p			Date	20c. Location	- City or To	wn, State
ij	Page ment ant: I		1 ☐ Burial 2 <b>X</b> Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Atlantic			10/1	5/2011	Glen B	urnie	, MD
Baltimore,	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Lig	nsee		22. Name and Ado						P.A.
	Physician/ Medical Examiner	iner	23a. Part 1. Enter the disease, or construction of the constructio	a. Due to (or as a of	VIO5C						nse	Approximate Interval Between Onset and Death
092	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d	consequence of):							
). Box 687	is that the death certific gned by the attending p be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregna☐ Other (specify)					ate of delive	ery Day Year
Js, P.O.	requires that been signed be should be det	[ 중	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause	given in Part	l. 				e cause of death?
Division of Vital Records,	The law rec cate has bee page 2 sho	Completed							24a. Was auto perfo 1 \square Yes	osy ormed?	Were autop prior to cor death? 1 \( \subseteq \text{Yes} \)	osy findings available impletion of cause of
ita	ician: certifi rector	m l	25. Was case referred to medical examiner?	Hospital:		T	Place of Deal	th (Check	only one)	12	2	1992
>	Phys this ral dii	2	1 Yes 2 No 27. Manner of Death	1 Inpatien	t 2 ER/Outpat	ent 3 🗆 DOA	4 L NL		-	dence 6 Oth		
n o	ding th. After fune	cate	1 Natural 5 Pending	(Month, Day,	Year) Zob. Time	W	pury at ork? □ Yes 2 □	- 1	28d. Describe r	now injury occur	red	
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	be 290 Place of Injury				-	28f. Location (S City or Tow	Street and Numb vn, State)	per or Rural	Route Number,
	ne Hospit n 24 hour ne Funera pletely fills	Medical	(Check 2 Medical Exa	nysician: To the best of m miner: On the basis of exa urse Practitioner: To the b	mination and/or inv	estigation, in my op	inion, death oc	ccurred at	the time, date a	and place, and du	ue to the cau	se(s) and manner stated.
	To the with To the COM		29b. Signature and title of certifier	Rapo,	Deput		nse number	54	,	29d. Date signe		
	#3		30. Name and address of person wh	Jones,	mD	Print) 695	Am	erli	eA	210	3.5	
	Stat Registra		31. Date filed (Month Day Year)	2011 32. Registrar's		hav.						
	- Hogisti t			- Annual Contraction of the Cont	~ p. p	pur vo						

JRV0 15+1

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

Cerald P. Sterner, MD 19 Chesapeake Beach Rd. East, Owings, Maryland 20736

D17245

October 19, 2011

Stormer M. D.

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	f Marylan		artment of F <i>tificate of E</i>	Health and M		201	21022
			1. Decedent's Name (First, Middle, Last)		Cer	uncate or L	Jeau I	2. Date of Death	g. No.	3. Time of Death $\rho$
	Physicia Medi	cal		nith				Octobe	2 Pay 18, 20	11 2:20
	Examir	ner	4a. Facility Name (if not institution, give street and num  Meritus Medical Center	ber)			Location of Death		4c. County of Dea	
1	Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. h	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Director	ı	217-32-7179 1 M M 2 F Superior F Decedent	77	Yrs.	Months Days	Hours Min.	(Month, Day, Y	934 Ma	ryland
	show lat	5	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Maryli 28a-f otifiec	Director	Maryland Washington	Ha	agerst	own				1 🎇 Yes 2 □ No
;	th the	al D	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
-	ath wi	Funeral	864 Jefferson Boulevard  11. Marital Status 12. Was Dece	dent Ever in U.S	S 13 V	21740	spanic Origin? (Spe	cify Yes or No-	U.S.A.	ovices Indian
ဖွ	ter de , or it	by F	1 X Never Married 2 ☐ Married	ces? 2  No 1  Q	52-	Yes, specify Cubar	n, Mexican, Puerto I	Rican, etc.)	Black, Whit	
9	ours at tural" al Exa	eted	3 ☐ Widowed 4 ☐ Divorced Year or Da		954	☐ Yes 2 🎇 No			Specify: Wh	ite
15.  -	72 ho an "na Medio	Completed	15. Decedent's Education (Specify only highest grade completed)	4 5 )	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)	ation <i>luring most of workii</i>	ng 1	6b. Kind of Business	Industry
212	withir giene ner th		Elementary/Seconday (0-12) College (1-12)	4 or 5+)	Se1	Employe	d		Redecor	ation
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. and Industriatif if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last)  Evan Bowman Smith			ļ	18. Mother's Name			
الح ا	ould by mark mark	Ė	19a. Informant's Name/Relationship (Type, Print)		19h Mailin	a Address (Street a		gdaline	Nunamake  ity or Town, State, Zi	
Ž	d 2 sh aalth au n 27 is ertrau		Jeanne F Singer/Guardian	ı					town, Mar	
ore	tof He If item or oth		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from 5	20b. P	Place of Dispo	sition (Name of natory or other place	e) D	ate 2	0c. Location - City or	Town, State
iti m	nt. Pag rtment rtant; njury o		4 Donation 5 Other (Specify)			Crematory			rederick,	
Bal	Depar Impor any ir		21. Signature of Funeral Service License	,			s of Facility Bas National		er Funera onsboro,	1 Home, PA MD 21713
			23a. Part 1. Enter the disease, or complications that ca shock or heart failure. List only one cause on each	aused the death	h. Do not ente	r the mode of dying	g, such as cardiac o			Approximate Interval Between
P	hysician/ Medical		Immediate Cause (Final	MATOR						Onset and Death
nut	Examiner		Due to (c	oras a consequ TABOLII		Dosij				Landy
	- 14	iner	Sequentially list conditions, b.	ir as a consequ		0000				weeks.
Cuted	and	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	isible		nded A	Marchin	<u> </u>		1-21tm.
760	physician and the burial-transit	alE	· ·	or as a consequ	ienceign): WCUM,		U			MENTITS.
3760 Eggte b		fedical		-1176	WECK!	د.ا			<del></del>	7.67411/3
× 68	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outc	ome of pregnar		Ectopic pregnancy	v		23d. Date of de	livery
P.O. Box	the att	Physician/M		ant at time of d		Other (specify)			Month	Day Year
о. Е	ed by	by Ph	Part II. Other significant conditions contributing to de	ath but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
dS,	an sign	g pa	MORBIO OBESTI	74		-		1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
COL	as ber	Completed	M/MLNUTHLAON O	N TUI	m Im	MEN RIVAL	MUTHUTON	24a. Was an autopsy		topsy findings available completion of cause of
He He	certificate ha							performe 1  Yes 2	ed? death?	s 2 No
<b>/ital</b>	certif	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:				r: — Check		-	
	er this neral d		27. Manner of Death 28a. Date o	npatient 2  if injury	28b. Time of injury	28c. Injury	4 □ Nursing Hor at 2	ne 5 L Residen 8d. Describe how	ce 6 Other (Specinjury occurred	cify)
iendiri	leath. or: Aff the ful	ifica	1 № Natural 5 ☐ Pending (Month) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	, Day, rear)	y	M 1 □ 1	Yes 2 No			
Division of Vital Records, talor Attending Physician: The law requires	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	4 Homicide determined 28e. Place of	of Injury - At hor g, etc. (Specify)		et, factory, office	2	28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
]	4 hours	Medical	29a. Certifier 1 Certifying Physician: To the beautifier (Check 2 Medical Examiner: On the basis	st of my knowle	edge, death o	ccured at the time,	date and place, and	I due to the cause	(s) and manner as sta	ated.
the	vithin 2 o the l	Me	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier	the best of my	knowledge, d	eath occurred at the 29c. License	time, date and place	e, and due to the ca	use(s) and manner as	stated.
	· ≽ <b>⊢</b> ō		3 -	no			46561	290	Oct 19.	2011
51 ·			30. Name and address of person who completed cause			int)		3 4	,	4 4 - 4-
LW.	-10+1 Stat		GUNTAULA OMIC 31. Date filed (Month Car) 2011 32. 6	gistrar's Signatu		ASTNA	Rom	1mgen	MIN MINON	21740.
	Stat Registra	e	31. Date filed (Month Car Year) 2011	Jistiai S Signati	1 6	allal				

DHMH 17 Rev 7/2009

Registrar DHMH 17 Rev 7/2009 C

Records,

P.O.

Division of Vital

State

			Pieas	e Type or Print II				•	-	
			For State	State of Maryla	•	artment of F <i>tificate of L</i>			201	1 21.021.
			Registrar  1. Decedent's Name (First, Middle, L	ast)	Cer	uncate of L	Jeani	2. Date of Death	eg. No. / U	3. Time of Death
paranet and	Physicia Medic	al	EDWIN M  4a. Facility Name (if not institution, gi	TUCKER	JR			Month ) 0	Day Year	1307™
-	Examir	ier	Mandrin Chesapea		use	Harwood	r Location of Death		Anne Aru	
	Funeral Director			Sex 7. Age (In yr. 12 M 2 F 86	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 4/21/19	9. B 25 Mar	irthplace (State or Foreign ountry) y Land
	nd now at	_	Usual Residence of Decedent  10a, State 10b, County	100	City, Town or Lo	cation				10d. Inside City Limits
	Varylar 28a-f sl	recto	Maryland Anne Ar		nnapolis					1 Yes 2 No
	with the I 23a or 2 ust be no	Funeral Director	10e. Street and Number 2728 Riva Road	•		10f. Zip Code 21401			0g. Citizen of What C	country?
	items items er m		11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.\	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - Am	
9000	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 M Yes 2 □ No If Yes, Give Year or Dates.		I ☐ Yes 2 🕅 No		riloan, etc.,	Black, Whi	hite
15-(	72 hoi n "nat Aedica	nple	15. Decedent's (Specify only highest of		(Give I	dent's Usual Occup kind of work done o O NOT use retired)	during most of worki	ng	16b. Kind of Busines	s Industry
212	ed within Hygiene. other tha ent, the N		Elementary/Seconday (0-12)	College (1-4 or 5+)		ner&Estim		τ	JS Naval A	cademy
Maryland 21215-0036	should be filed n and Mental Hy 7 is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last Edwin M. Tucker,				18. Mother's Name Teresa		aiden Surname) ed1	
, Man	2 ± 2 ±		19a. Informant's Name/Relationship Dawn Tucker/ Dau						City or Town, State, 2 gs, MD 207	
Baltimore,	ge 1 and nt of Heal :: If item; or other		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	p. Place of Dispo	sition (Name of natory or other place	re) 10/17		20c. Location - City o	
altin	permit. Page 1 a Department of H Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	/ /			ss of Facility Ka1			, Maryland
Ä	permi Depar Impo any ir	) J	June 8	Calas, 11.	29	973 Solom	ons Islan	d Rd. Ed	lgewater,	MD 21037
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-	Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
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	be executed sician and burial-transit	cal Exa	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):					
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Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautified in the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1  Live Birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnand Other (specify)	ey		23d. Date of d Month	elivery Day Year
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Division of Vital Records, P.O.	The law cate has I page 2 s	Completed						24a. Was an autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of
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of V	g Physer this eral di	e: To	27. Manner of Death	1 ☐ Inpatient 2 28a. Date of injury	28b. Time of	28c. Injury	4 ∐ Nursing Ho	me 5 □ Resider 28d. Describe hov	nce 6 Other Spe w injury occurred	HOUSE HOUSE
ion	tending leath. or: Aftr the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not		injury	M 1 □	? Yes 2 □ No			
Divis	To the Hospital or Attending Physician: The kawitin 24 Hours after death.  To the Funeral Director: After this certificate hat completed filled in by the funeral director, page		4 Homicide determined			eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	he Hosp in 24 hou ne Funei pleted fil	Medical	29a. Certifier (Check (Check Check C	ysician: To the best of my kno niner: On the basis of examina nse Practions: To the best of	owledge, death o tion and/or invest	occured at the time igation, in my opinio	, date and place, and on, death occurred at	d due to the caus the time, date and	e(s) and manner as s I place, and due to the	tated. cause(s) and manner stated.
	To the with Comment	-	29b. Signature and title of certifier	Dent.	im	29c. License	number V1438		Od. Date signed (Mon	172011
N	115		30. Name and address of person who		em 23a) (Type, P	rint) DECE	USE Ha	14 ANA	JAPOLIS M	1021401
	Stat	е	31. Date filed (Month, Day, Year)	32. Rosetrar's Sign		1 PCIE	V JC	1/11/11		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State	State of Ma	aryland	•			d Mental H	ygien	e	1 01 005
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Physicia Medic		MARTIN JO	SEPH	T	RAV	ERI		2. Date of D Month		year 20	
Examin	er	4a. Facility Name (if not institution, giv Anne Arundel Med	·	er		4b. City, Town, c		eath		c. County of De Anne Ar	
Funeral Director			6ex 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of B (Month, D	ay, Year)		irthplace (State or Foreign country) lifornia
nd ihow at	J.	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation		10/12	1192	1 00	10d. Inside City Limits
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urs aff tural",	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates. 4	3-69		1 ☐ Yes 2 🛣 No	Specify:			Specify: W	hite
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ge 1 and 2 should be t of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship ( Mary Travers – Wi				ng Address (Street Meadow			-		
of Head Fitem		20a. Method of Disposition	-	20b. Pla	ce of Dispo	sition (Name of matory or other pla		Date Date		ocation - City o	
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permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once.		21. Signature of Funeral Service Licen	see	1		2. Name and Addre		John M.	Tayl	or Fune	ral Home
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	applications that caused	the death.						шаротт	s, MD 21401 Approximate
Physician/		Immediate Cause (Final disease or condition	Ocu	le (	rove	zertia	1 Hea	rotfaile	m,		Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of): $\zeta$	)	:15	TU			:000,00
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Physi this c ral dire	<u>۵</u>	1 Yes 2 No	Hospital:  1 Inpatie  28a. Date of injur		R/Outpatier	nt 3 🗆 DOA Oth	4 L Nursing	Home 5 Res			ecify)
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e Hospit 24 hour e Funera etely fill	Medical	(Check 2 L Medical Exam	rsician: To the best of n iner: On the basis of ex se Practitioner: To the	amination a	and/or invest	igation, in my opini	on, death occurre	ed at the time, date	and place	e, and due to the	cause(s) and manner state
To the within to the comp	_ [	29b. Signature and title of certifier	1			29c Licens	e number		204 D	to signed (Mon	th Day Your
410+1		30. Name and address of person who MicHAEL. 31. Date filed (Month, Day, Year)	completed ause of de	ath (Item 2	3a) (Type, P	Tint) DAFER	K F H	wy An	INA	POLISM	ND 27401
State Registra	_	31. Date filed (Month, Day, Year) 0CT 17 2	011 32. Registrar	's Signatur	B. 4	hares		1			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ Month nan Medical 0 Examiner County of Death Valley Nursing Hone lontagne 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or oreign **Funeral** If Under 1 Year Director Bartimore, MD Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Hyattsville 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6701 Adelphi Road 20782 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1947–1949 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Dentist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Dora "Unknown" Aaron Totz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Adelphi Road Hyattsville, MD 20782 Health a Dorothy H. Totz - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
National Crematory 1 Burial 2 X Cremation 3 Removal from State 10/7/2011 Falls Church, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Edware and Asiasse of Family neral Direction Inc. 1091 Rockville Pike Rockville MD 20852 M01163 23a. Part I for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) nding physician and use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular Disease 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗌 Yes Completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital No. Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 255620175 05 Print 23a) (Type, Print 235 Potomac Valley Road Rockville MD 20853 State Registrar

11-07522 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tekabech G. Taye State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 7, 2011 TEKABECH **Medical Examiner** GEBRETSADIK TAYE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 700 Ray Road Hvattsville Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Davs Hours 1 M 2 F 30 Jan 5, 1981 577-37-5334 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location TAKOMA PARK 28a-f show PG be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6731 NEWHAMPSHIRE AVE. 20912 ETHIOPIA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes jes 1 and 2 should be filed within 72 hours after de of Health and Mental Hygiene.

If item 27 is marked other than "natural", or i Black 3 Widowed 4 X Divorced If Yes, Give Year Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private SECURITY 12th 2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) GRAWORK YETRU TAYE GLTSADICK Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M 9500 NOTTINGHAM DR. UPPER MARLBORO Md. 20772 NETSEREAB TAYE (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, permit. Pages 1
Department of H
Important: If it crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10-17-11 Family Cemetery Donation 5 Other Specify 21/Signature of Funeral Service Lipense **Physician** failure. List only one cause on each line /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical fing physician a UNPENDED AMENDED Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 Completed autopsy performed? certificate ✔ Yes 2 No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medica 26.Place of Death (Check only one) å examiner? Hospital: 1 Inpatient this 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury FOUND: Day, Year) After 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Subject shot 1 Natural FOUND: Pending 1 Yes 2 ✔ No death. Director: Oct 7, 2011 0000 hrs Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be (Specify) Local Street 4 V Homicide

20c. Location - City or Town, State ETHIOPIA 22. Name and Address of Facility W.H.BACON FUNERAL HOME 2447 14+b CT NW WASHINGTON D.C. 20010 3447 14th ST. NW WASHINGTON D.C. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval en Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes Other Nursing Home 5 Residence 6 🗹 Other: Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 700 Ray Road , Hyattsville , MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 8 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certil 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Registrar's Signat State Registrar **ORIGINAL** OCME

1450 hrs

Foreigh IIOPIA

10d. Inside City Limits

1 YYYes 2 No

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Physician/ October Pay 14 2011 11:35P Dorothy Aaron Travers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Cambridge Chesapeake Woods Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Hours October 4 Months Mary Land 4,1922 89 220-10-6033 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Director 1 Yes 2 X No Cambridge Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 USA 3012 Old Route 50 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education بالم filed with. \*عا Hygiene. خ**er than** "الا (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Clothing College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Seamstress and Mental Hygien ris marked other tl Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anna Mae Mooney Orville Moore and 2 should b Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 27555 Crisfield Marion Road, Marion Station, MD21838 William L. Aaron/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 X Buriai 2 Cremation 3 Removal from State Veterans Cemetery | 10/19/2011 Beulah, Maryland 4 ☐ Donation → ☐ Other (Specify) 21. Signatur of Funeral Service Licen Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 ard 1. Enter the disease, or complications that cook, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition Pnysician/ Atherosclerotic Cardio vascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Vear Day Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k Completed by dementia Hypertension 2 XNo 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Hypothyroidism 24a. Was an autonsy 1 Yes 2 🗌 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 27. Manner of Death Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending M Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page

(Check

3 🗆

29b. Signature and title of certifier

rson who completed cause of death (Item 23a) (Type, Print) 30. Name and 100 Bramble Street Cambridge MD 21613 ohnson

State

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rita F. Vance October. 2011 11:32 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Hours 0670971949 218-52-9229 Georgia 62 Director Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Anne Arundel Edgewater Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 21037 United States 3315 Kenney Lane Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: ıral", or item Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 White "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) il Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Cook Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ೦ Richard C. Snyder, Sr. Marie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 3315 Kenney Lane, Edgewater, Maryland 21037 Anthony R. Vance/Husband 20a. Method of Disposition
1 Å Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Lakemont Mem. Gardens 10/15/2011 Davidsonville, MD 4 Donation 21. Signal re o Fundal S 22. Name and Address of Facility George P. Kalas Funeral Home vice Licent 2973 Solomons Island Road, Edgewater, MD 21037 or complications that caused the death. Do not enter the mode of dying, 23a, Part 1. Enter the disease Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ò Month Year Day should be detached the Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? certificate Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation apleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 16376

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:40 P M Francis Raymond Weems Oct 16 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert. Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 23 1943 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 67 Maryland Director <u>216-40-7681</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Maryland Calvert Port Republic 1 ☐ Yes 2 1 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3001 St. Leonard Road 20676 United States by Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, If a Medical Exercitise once. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mechanic. Auto 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Madolyn Sewell Maurice A. Weems, Sr. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne B. Weems - spouse 3001 St. Leonard Rd. Port Republic, MD 20676 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Episcopal Cemetery Oct 19, 2011 Port Republic Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OF DEMENTIA **Physician** COMPLICATIONS O O WITH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIFFICELE 1 Yes 2 Ho 3 Probably 4 Unknown OBSTRUCTIVE URGAA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? this certificate 1 Tyes 2 2 To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Andrsing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

JRW) 15

the death certificate be executed

The law requires that

P.O. Box 68760,

of Vital Records,

Division

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

TOHA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

WEIDER, M) - PRINCE FREDERICK M)-206

29d. Date signed (Month, Day, Year)

32. Registra s Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 258

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan		tificate of L		, ,	ene g. No. ○ ○ 1	
		3	Decedent's Name (First, Middle, Last)					2. Date of Death	201	3 Jime of Death
	Physici /Medic		Shirley Wa	nder				October	<sup>D</sup> 1, 201	1 11:35 A.M
	Examin	er	4a. Facility Name (If not institution, give st	· _			Location of Death		4c. County of D	
<b>*</b>			South River Health  5. Social Security Number 6. Sex	& Kehab Cent		Edgev	vater If Under 24 Hrs.	8. Date of Birth		arundel  Birthplace (State or Foreign
	Funeral Director			м 2 <b>X</b> ) F 80		Months Days	Hours Min.	(Month, Day, 09/04/1	931 Wa	Country) ashington, DC
	/land ow at		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD Anne Arun	del	Edgewa	ter				1 ∐Yes 2 XX No
	ith the	Director	10e. Street and Number	•		10f. Zip Code		10	g. Citizen of What	
	s 23a		144 Washington			1	1037		U.S.	A •
20	be filed within 72 hours after death with the Maryland Hylgiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Will Wildowed 4 Divorced	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 No If Yes, Give</li> </ol>		Nas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2ሺ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black, W	hite, etc.
9500-61212	tural tural		15. Decedent's Educ	Year or Dates:	16a. Deced	lent's Usual Occupa	ation	1	6b. Kind of Busine	white   ss/Industry
ر د اع	hin 72 3. In "na Medio	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done o OO NOT use retired	luring most of work	ing		
7	ed with	Completed	12			nurse			nursing	home
Maryland	eve be	Be	17. Father's Name (First, Middle, Last)	0.1.1			18. Mother's Name		,	Voltor
<u> </u>	2 should be f and Mental I is marked of raumatic eve	은	John Franci  19a. Informant's Name/Relationship (Typ		19b Mailin	a Address (Street	Della and Number or Run	Made:		Volter
Z Z	nd 2 s lth an 27 is r traur		Della M. Skrok, da	*		-	y Circle,		-	17268
<u>ā</u>	ges 1 and 2 should nt of Health and Mer If Item 27 is marke or other traumatic		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other plac	1 1		Oc. Location - City	or Town, State
Ē	Page Tent o Int: If		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify				atory 10/	18/11	Alexandri	ia, VA
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once.		21. Sharture of Funeral Service Licen	Lecarest		Name and Addres	ss of Facility Ra armony La		eral Home	
ľ	193		23a. Part1. Enter the disease, or complice shock, or heart ailure. List only one	ations that caused the deatle						Approximate Interval Between
	Physician	2 1	Immediate Cause (5° al disease or condition			EROSI				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent						
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	nsit	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a consequ	derice ory.					
,	execu in and ial-tra	Examiner	resulting in death) Last	Due to (or as a consequence	uence of):					
09/89	ifficate be executed g physician and as the burial-transit	edical	d.							
		Med	IF FEMALE:							
X POX	death cer e attendir d for use	sician/M	23b. Was decedent pregnant in the past 12 menths?	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
oj	the de	hysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	9□Unknown	eath 5L					
	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions conf	tributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.			e to the cause of death?
cords	requires been sign hould be	Completed						1 ☐ Yes		
Ō	e la has je 2	mple						24a. Was an autopsy perform	/ prior	e autopsy findings available to completion of cause of
	ician: The I certificate ha ector, page		25. Was case referred to medical				00 Di(D	1□ Yes 2	<b>Ø</b> No 1 □ 1	res 2□No
5		o Be	examiner?	ospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Othe		h <i>(Check only one</i> me 5□ Besider	nce 6 🗆 Other (5	Specify)
ס	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe how		эреспу
000	ttendln leath. tor: Af the fur	atio	1 Natural 5 Pending 2 Accident investigation	(Monus, Bay Year)	,,		Yes 2 □ No			
DIVISION	al or Attending F s after death. I Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number of , State)	r Rural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Ce	29a. Certifier 1 ☐ CertifyIng Phys	Iclan: To the best of my kno	wledge, death	occurred at the tir	ne, date and place	and due to the ca	use(s) and manne	r as stated.
	e Hos 124 h e Fur letely	ledical		er: On the basis of examina and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (M	onth, Day, Year)
			Ane Be	ex or		RIW	3758		10/17/11	
لم	RW a		30. Name and address of person who cor		_		(	D		
	Sta	ete.	31. Date filed (Month, Day, Year)	SNETT CRNI		MADHU	NGTON	KD EDE	KWATER	MD 21037
	Pogiet			2011	B	hard 1				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

cian. dica	/ il		JOSEPH	WALTERS					2. Date of De Month OCTOBE		201 <sup>Year</sup>	3. Time of Death
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al		307 OLD :	ımber 6	. Sex 7. A	Age (In yrs. I	ast birthda		If Under 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Forei
or		264-22-663 230-30-8		1 X M 2 □ F	89	Yrs.	Months Days	Hours Min.	077757	1922	2 MAR	YL'AND
To Do O consultated by Freeder Bissess	. Т	Jsual Residence of I 10a. State	10b. County		10c. Cit	y, Town or	Location					10d. Inside City Limi
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	Funeral Director	10e. Street and Num		T DOAD			10f. Zip Code	0		_	tizen of What Co	·
	<u> </u>	11. Marital Status	D POINT	12. Was Deceden		6. 1:	2161 3. Was Decedent of H		pecify Yes or No-		ITED STA 14. Race - Amer	
i	[ 출	1 Never Marrie	ed 2 Marrie	Armed Forces 1 X Yes 2 [ If Yes, Give	? □ № 194	2-	If Yes, specify Cuba  1 ☐ Yes 2 🔀 No		o Rican, etc.)	-	Black, White	
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	o Re	17. Father's Name (F ADAM W		st)					ne (First, Middle,			
	ŀ	19a. Informant's Nai		(Type, Print)		19b Ma	ailing Address (Street	•	RESA AUC			Code
		PATRICIA	MUSSER	/ DAUGHTE	R		SECOND AV					
	-	20a. Method of Disponential 2		Removal from Sta	20b. F	lace of Dis	sposition (Name of rematory or other plac AKE CREMAT	PON OCT	Date 17,	20c. L	ocation - City or	Town, State
	-	4 Donation	5 Other (Sp.	ecify)	CHE	CEI	NTER	2011	2011		EVENSVIL	•
		21. Signature of Eur	leral Service Lic	erisee A			FELLOWS, F	ÎELFENBEI	N & NEW	NAM D M	FUNERAL D 21619	HOME, P.A
r	1	23a. Part 1. Enter th	ne disease, or co	omplications that caus	ed the deat					_	21015	Approximate
		Immediate Cause (F disease or condition	inal	y one cause on each in		000	kinson					Onse and Death
		resulting in death)		Due to (or a	s a consequ	uence of):						<u> </u>
ģ		Sequentially list cor if any, leading to imi	mediate	b. — Due to (or a	s a consequ	ience of):						
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Dhycician/Madi	M	F FEMALE: 23b. Was decedent p		23c. If yes, outcom 1 ☐ Live Birth			3   Ectopic pregnance				23d. Date of del	ivery
icio		in the past 12 m 1  Yes 2 9  Unknown		4 Pregnant	at time of o		5 Other (specify)	.у			Month	Day Year
			cant condition	s contributing to death	but not res	ulting in th	e underlying cause giv	ven in Part I.	23e. Did to	obacco i	use contribute to	the cause of death?
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plet	Completed by								24a. Was			opsy findings availab completion of cause o
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a	וֹ מ	25. Was case referre examiner?	-	Hospital:			Oth	ace of Death (Che				
	<u> </u>	27. Manner of Death		28a. Date of in	jury	28b. Time	of 28c. Injur	4 LI Nursing F	lome 5 A Resident		Other (Special Occurred)	fy)
finat		1 Natural 2 Accident	5 Pending Investiga		)ay, Year)	injury		? Yes 2 \( \subseteq No		,	,	
itio	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could no determin	ed 28e. Place of It	njury - At ho etc. (Spec <i>ify</i>		street, factory, office		28f. Location (S City or Tox		nd Number or Rui	al Route Number,
	Medical	29a. Certifier 1	Certifying P	hysician: To the best of aminer: On the basis of	of my knowl	edge, deat	th occured at the time	, date and place, a	and due to the ca	ause(s) ar	nd manner as sta	ted.
M		only one) 3	☐ Certifying N	lurse Practioner: To th	ne best of my	knowledg	e, death occurred at th	e time, date and pla	ace, and due to th	ne cause(	s) and manner as	stated.
- 1	- 1	.o.b. Oignature and ti	I'm oi comilei	Sever	110		29c. License	21.21			te signed (Month	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/12 72011 Year 1805 Robert E. Wilde Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 13K3KM 2 | F Hours Min 218-30-6329 *57147193*3 **Director** 78 Usual Residence of Decedent 28a-f shov death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at irector 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Arnold 1 ☐ Yes ※X No ö 10e. Street and Number 10g. Citizen of What Country? Funeral 20764 USA 1174 Steamboat RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U.S Armed Forces? 14. Race - American Indian, þ Black, White, etc 1 Never Married 2 Married 1 Yes 2XXNo 72 hours after Maryland 21215-0036 White 1 Yes 2XXNo Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Painter Residential Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Hunter Ferdinand Wilde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Wilde Son 1174 Steamboat Rd. Shady Side, MD 20764 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory 1 Durial 2 Cremation 3 Demoval from State 10/14/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) neumon14 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or imjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No be detached for Year Pregnant at time of death ed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Certificate: To hours after death. uneral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be completed filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mont)

cal

made

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart		Mental Hygie	ne	
				icate of Death	Reg.	No. 20	31.81.1.
Р	hysicia	ın/	Decedent's Name (First, Middle, Last)     Norma Jean Lewis Wright		2. Date of Death _Month _	Day Year	3. Time of Death
£oc.	Medic			0.7		15, 2011	12:03 A.M
	Examin	er	Holy Cross Hospital	b. City, Town, or Location of Death Silver Spring	1	4c. County of Death  Montgome:	rv
F	uneral			f Under 1 Year If Under 24 Hrs.		9 Birthola	ace (State or Foreign
	rector			onths Days Hours Min.	(Month, Day, Yea	ar) <b>1949</b> Country	New Eagle,
70	M o M		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location		February		sylvania
ırylan	ied a	Director	10a. State 10b. County 10c. City, Town or Location			100	d. Inside City Limits  1 X Yes 2 \( \square\) No
e Ma	notif	Dire	Maryland Montgomery Wheaton	1 10f. Zip Code		. Citizen of What Countr	
vith th	23a c st be			20902		United Stat	´
eath v	tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Sp. s, specify Cuban, Mexican, Puerto		14. Race - American	
ie Q	, or it	by F	1 Never Married 2 Married 1 Yes 2 No		o Rican, etc.)	Black, White, et	c.
003 urs at	ural"	ted	3 ☐ Widowed 4 🗶 Divorced If Yes, Give Year or Dates.	Yes 2X No Specify:		Specify: Blac	CK
15-1	"nat ledica	ıple	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	's Usual Occupation of work done during most of work	king 16	b. Kind of Business/Indu	ıstry
ithin ene.	r thar	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Medical	OT use retired)  Imaging Superv	visor H	oly Cross H	lospital
led w	other ent, 1	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		ooprear
rlan I be fi	rked tic ev	To	Robert Lewis	Dane1		· ·	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Oppartment of Health and Merital Hygiene.	is ma auma			ddress (Street and Number or Ru			
nd 2 sealth	m 27 ner tr		Krystal Michelle Wright (Daughter) 140	4 Windham Lane;	Wheaton,	Maryland 2	0902
Ore le 1 a t of H	If itel		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition  cemetery, cremato.	on (Name of ary or other place) Oct	Date 2001	c. Location - City or Tow	n, State
timen tmen	tant;		4 Donation 5 Other (Specify) Riverdale	e Park Gremator	y R	iverdale,Ma	
<b>Bal</b> permi Depa	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			and Address of Facility R.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	.;600 Kennedy St			
Dhan			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	o mode of dying, adon as cardiae	or respiratory arrest,	3	Approximate nterval Between Onset and Death
	sician/ edical		disease or condition resulting in death)  Breast Cancer  a. Due to (or as a consequence of):			3	years
Exa	miner						
vego,		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying			3	
cuted	nd transi	Examiner	Cause (Disease or injury that initiated events c.				
е ехе	hysician and the burial-transit	alE	resulting in death) Last Due to (or as a consequence of):				
ivision of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be executed after death.	physi	edical	d			-	
Box 687 death certifica	attending p	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			Ond Date of delices	
ox eath o	atten I for u	iciar	in the past 12 months?	topic pregnancy her (specify)		23d. Date of delivery Month D	/ ay Year
<b>. B</b>	igned by the a	Physician/Me	9 Unknown				
<b>P.O.</b> s that the	ned t	by P	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobaco	co use contribute to the	cause of death?
ds, quires	been sig should b				1 🗆 Yes	2 X No 3 ☐ Proba	bly 4 🗌 Unknown
Records, The law requires	as be	Completed			24a. Was an autopsy		y findings available pletion of cause of
He He	cate has				performed	? death? No 1 \sum Yes 2	□ No
ician	0 =	m ,	25. Was case referred to medical examiner?  1  Yes 2 X No Hospital: Y Institute 2  FR(C) that is the 2	26. Place of Death (Chec	ck only one)		
Phys	in la	2	1 X Inpatient 2 ER/Outpatient 3  27. Manner of Death 28a. Date of injury 28b. Time of	DOA Other 4 Nursing H		6 Other (Specify)	
on C	: Afte	cate	1 X Natural 5 ☐ Pending (Month, Day, Year) injury	work?  M 1 Yes 2 No	28d. Describe how in	ijury occurred	
Division of Vital talor Attending Physicians after death.	<b>Director;</b> After this in by the funeral of	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f			and Number or Rural R	oute Number,
Div talor rs afte			building, etc. (Specify)	J	City or Town, St	ate)	
the Hospital	Funeral Dir	edical	29a. Certifier (Check 2 Medical Examiner: On the bast of my knowledge, death occur	rred at the time, date and place, a	and due to the cause(s	s) and manner as stated	e(s) and manner stated
the F	ro the r	<b>∑</b> !	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, deat 29b. Signature and fittle of certifier	th occurred at the time, date and pl	ace, and due to the ca	use(s) and manner as sta	ted.
P vit	2 8 ⊀		200. Organical grid pure of contribut	29c. License number D54378		Date signed (Month, Date tober 15,	
	,	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			,	
2			Cheryl Aylesworth, M.D.; 2730 Universi	ty Blvd.West:Su	ite 400:W	heaton.Marv	land 20902
	State	_	31. Date filed (Month, Day, Year) 32. Registrats Signature				
R	egistra	r	OCT 1 9 2011 Severa B. Agarles				

DHMH 17 Rev 06-2011

34845 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 20 Î Î WADDELL 6:40 A VIRGINIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL Social Security Number 6. Sex . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. Country) Director 226-12-5166 94 1/26/191 WW Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Harford 1 🗆 Yes 2 🗓 No Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3018 Dublin Road 21154 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked Attack. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black. White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: White 3√2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Harvey Wingo Perkins Eva Lee Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Bradford Button / ant of Hea t: If item 2, r other tr 2776 Sharon Road Jarrettsville, MD 21084 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Rock Run Cemetery 10/10/2011 Havre De Grace, MD Signature of Suneral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, IA Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a nonsequence of attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an The law After this certificate has autopsv performed? Yes 2 No death? ☐ Yes 1 Tes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director. Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32299 October 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR MD 21014 31. Date filed (Month Page Registrar's Signature State 1 201 Darke Registrar

34846 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20, Sharon Ann Younkins 2011 1:06 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8502 Old National Pike Boonsboro Washington 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 23, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Hours Min. Maryland Yrs 218-62-9151 60 **Director** 1951 Usual Residence of Decedent 28a-f show 10b. County 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 8502 Old National Pike 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretarial State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of မ Gerald Younkins Della M. Deener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della M. Younkins/mother 8502 Old National Pike Boonsboro, Maryland 21713 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brownsville Heights 10/23/2011 | Brownsville, Maryland . Signature of Funeral S 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Erver the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caused in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ adenocarcinoma disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific D68995 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yong Tang, AD 1130 opal 4, Haferstown, NOD State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Baltimore, Maryland 21215-0036

68760

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law

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	_	For State Registrar			ai yiai		rtificate of l		, 0	g. No. 2		34847
Physicia		1. Decedent's Name		st)					2. Date of Death Month	Ogay 20	Year	3. Time of Death 3-135-P M
Medic Examin		4a. Facility Name (if	not institution, giv	street and number)				r Location of Death	1 /	4c. Count Anne		h
Funeral		5. Social Security No	umber 6. 3			ast birthday)	Annapol  If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birt	hplace (State or Foreign
Director		039-18-9 Usual Residence of		□м 2 🔭 Г	82	Yrs.	Months Days	Hours Min.	04/28/1	929	Norv	wood, MA
-f shov	Director	10a. State	10b. County			y, Town or Lo	ocation					10d. Inside City Limits
or 28a	Dire	10e. Street and Nun				enton	10f. Zip Code		10	g. Citizen of	What Co	1 ☐ Yes 2 🛣 No untry?
ms 23a must b	Funeral		denton R	oad Unit 3			2111			USA		
, or iter	by Fu	<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ied 2 Married	12. Was Decedent I Armed Forces? 1  Yes 2	Ever in U.S No		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto			ce - Ame ack, White	rican Indian, e, etc.
atural"	eted	3 Widowed	Divorced  15. Decedent's B	If Yes, Give Year or Dates.			1 Yes 2 No			Specif		nite
than "n e Medi	Completed	Elementary/Seco	cify only highest gr onday (0-12)		i+)	(Give life. D	kind of work done of NOT use retired)	during most of work	king	16b. Kind of I		
Hygier other i	a	12 17. Father's Name (F				Machi	ne Operat	T	ne (First, Middle, Ma			oducts
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alth and 27 is n		19a. Informant's Na		Type, Print)  Daughter			ng Address (Street  Marion			-		Code)
permit. Tage I am 2 should be the within 12 hours after best fiving the waryand permit. I feath and Mental Hyglene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	osition	Removal from State		lace of Disp	osition (Name of matory or other plac	ce)	Date 2	loc. Location	- City or	
artmen bartmen cortant: injury e.		4 ☐ Donation	5 Other (Speci	'fy)	At1	1.0	Cremator  2. Name and Addre			Glen B		
and in the contract of the con		Day	+ 11			I	lardesty :	Funeral H			nnap IIIs	olis Road ,MD 21054
nysician/ Medical		23a. Part 1. Enfects shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List only o Final	applications that caused one cause on each line a.	rel	2~14	ter the mode of dyin					Approximate Interval Between Onset and Death
xaminer		Sequentially list cor	aditions (	Due to (or as	a consequ	uence of):						/
ınsit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying linjury	Due to (or as	a consequ	uence of):						
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ng phys as the t	Medic	IF FEMALE:		d								
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	ıldeath 3[	☐ Ectopic pregnand ☐ Other (specify)	су			ate of del	iv <b>ery</b> Day Year
gned by be deta		Part II. Other signifi	icant conditions	contributing to death b	ut not res	ulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use con	tribute to	the cause of death?
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ate has bage 2	Completed								autopsy perform	ed?	prior to death?	completion of cause of
certifica rector, I	Be	25. Was case referre examiner?  1  Yes 2	ed to medical	Hospital:			Oth	lace of Death (Chec		( <del>************************************</del>	1 🗆 100	2 110
ter this	te: To	27. Manner of Death		1 🖃 Inpati 28a. Date of inju (Month, Da	ry	28b. Time o injury	nt 3 🗆 DOA	4 ∐ Nursing He y at	ome 5 Resider 28d. Describe hov			ify)
death. ctor: Ai y the fu	Certificate:	2 Accident 3 Suicide	Investigatio	n De Rhan of Init				Yes 2 No	28f. Location (Stre	oot and Alumi	har ar Pu	ral Pouto Number
ral Dire		4  Homicide	determined	building, etc	. (Specify	)			City or Town,	State)		
hin 24 hou the Funer	Medical	(Check 2 only one) 3	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	kamination	and/or inves	stigation, in my opinio	on, death occurred a	it the time, date and	place, and d	ue to the	cause(s) and manner stated.
wit. Co⊓		29b. Signature and t	title of certifier	Chu			29c. Licens		29	d. Date sign	O (Month	n, Day, Year)
<i>\$1</i>		30. Name and addre	ess of person who	completed cause of d	2 / U	23a) (Type,	Druh Druh	2 03 6 Drive (	Che. Lu	M)	2/6	18
Stat	G	31. Date filed (Month	n, Day, Year)	011 32. Registra	r's Signat		1-11					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 18. 20°11 1:09 AM William Zimmerman Jr. George Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Beach Anne Arundel Albany Avenue Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F 12718/1925 **Director** 579-26-1769 Washington, DC 85 Usual Residence of Decedent 10a. State the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Tyes 2 No Anne Arundel North Beach 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 7044 20714 Albany Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 M Married Completed by X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: "natural", 3 Divorced 4 Divorced If Yes, Give Year or Dates<u>1</u>943–46 Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 installer home furnishings Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H of Health and Mental of Health and Mental of item 27 is marked of r other traumatic ever ပ William Birtha Simpson Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis B. Zimmerman, son 654 Alabama Avenue, North Beach, MD Important; If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/17/11 Alexandria, VA 4 Donation 5 Other (Specify) Structure of Funeral Service License Rausch Funeral Home, P.A. 22. Name and Address of Facility 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ DIABETES disease or condition resulting in death) ENRS Medical Due to (or as a consequence of) **Examiner** DNCREDTITIS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Unknown cate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy hours after death. Ineral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate; To Be examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D29651 201 dRW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+

Registrar DHMH 17 Rev 7/2009

State

Charles A.

31. Date filed (Month, Day, Year)

Judge,

M.D.,

2011Þ

32. Registra Signature

110 Hospital Rd., Suite 310, Prince Frederick, MD

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2011 4:00 A M KAREN ALESSI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALICE MANOR NURSING HOME BALTIMORE N/A8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** 1 □ M 2 🗓 F Days Hours 0171571951 Director 500-50-7603 60 IN Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1xx Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2095 ROCK ROSE AVENUE 21211 USA ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" 3 Widowed 4 XDivorced Specify Completed WHITE of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ RICHARD JOSEPH POLAKOFF ELINOR BINDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 BONHOMME WOODS DRIVE, ST. LOUIS, MO ELLEN BINDER/COUSIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 11/01/2011 TOWSON, MD e of Fineral S 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronce disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner gerone Sequentially list conditions. Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last  $\mathcal{D}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? δ 124/20/lens Completed 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes Other: 2 410 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD D 31464 101 31111

State Registrar SHOAIB

31. Date filed (Month, Day, Year)

NOV 0 2 2011

MD

821 N. EUTAW ST Finte 308 BALTMOREMD 21761

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SKMI

PATIENT KNOWN AS WILLIE MAE ALSTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05:00 AM Willie Mae Alston OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL HOSP OF BALTIMORE N/A BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 5 Spain Security Number 1 Director 1 □ M 2 🕱 F 06/23/1931 Maryland 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1X Yes 2 No N/A Baltimore MD 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral **2**3a VIT-U.S.A. 3821 Roland View Ave. 21215 ural", or iter 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: Black 3 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " lementary/Secondary (0-12) College (1-4 or 5+) Montgomery Wards the Catologue Review Clerk 12th Grade Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | ၉ Willie Estelle Williams Wayman Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3821 Roland View Ave., Baltimore, MD 21215 Rev. Dwight Thomas Sr. (son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/07/2011 <del>11/03/11</del> One Silter Cremeters King Mem. Park 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph des of Brown Jr Funeral Home 2140 N. Fulton Ave., Baltimore, PA MD Home 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

BAYS Immediate Cause (Final Ph\_sician/ RESPIRATORY FAILURE HYPERCAPNIC disease or condition resulting in death) Medical Due to (or as a consequence of): MORE THAN Examiner DISEASE CHRONIC OBSTRUCTIVE 10 YEARS Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, Hospital or Attending Physician: The law requires
 Hours after death.
 Funeral Director: After this certificate has been sign 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed' 1 ☐ Yes 2 ☑ No 1 Yes 2 No **Division of Vital** filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the f only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RyMehra M.D RES-000 OCTOBER, 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

RUTIKA MEHTA

NOV 0 2 2011

31. Date filed (Month, Day, Year)

M.D.

SINAL

32. Registrar's Signature

OF

BALTIMORE

HOSP

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		. For	State of M	aryland	/ Depa	rtment of H	leaith and	Mental Hy	giene	
		State Registrar			Cert	ificate of E	Death		Reg. No. 20	34851
Physicia	an/	Decedent's Name (First, Middle, Las	,					2. Date of Dea	ath 2 27, 2011	3. Time of Death
Medi Exami		Elizabeth M. Buch 4a. Facility Name (if not institution, give				4b. City, Town, or	Location of Deal		4c. County of [	
LAGITII	ici	Montgomery Hospic		louse			ville			gomery
Funeral		5. Social Security Number 6. Se		e (In yrs. Ias		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	h 9.	Birthplace (State or Foreign
Director		423-60-7697 1 Usual Residence of Decedent		77	Yrs.			December	1, 1933   A	Country) Labama
/land f shov	tor	10a. State 10b. County		10c. City,	Town or Loca	ation				10d. Inside City Limits
e Man r 28a- notifie	Director	Maryland Montgome 10e. Street and Number	ery			Bethes	sda			1 🗆 Yes 2 🖾 No
with th 23a o Ist be		10106 Crestberry	P1000				817		10g. Citizen of Wha United	
death vitems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. W		spanic Origin? (S	Specify Yes or No-	14. Race - A	American Indian,
after after xamin	d by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give	No		Yes 2 X No		to Alcan, etc.)	Black, V Specify:	White, etc. White
hours	Completed	15. Decedent's Ed			16a. Decede	nt's Usual Occupa	ation		16b. Kind of Busin	
Z15 Din 72 De. han "u	l mo	(Specify only highest gra Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DO	nd of work done of NOT use retired)		rking		
land 21215-0036  be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	5+		Mus	sic Direc				nd Education
lanc be file ental l rked o	10	Edwin H. Moore						me (First, Middle, e Floyd	Malden Sumame)	
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	en a	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailing	Address (Street a			r, City or Town, State	, Zip Code)
e, M and 2 s Health tem 27		John H. Buchanan	/ Husband	_			rry Plac	e, Bethe		land 20817
A U L		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	20b. Pla Mont	ce of Disposi netery, crema <b>2011 e r</b> y	tion (Name of ptory or other plac im, Inc.	e) Nove	ember 1,	20c. Location - Cit	
		4 ☐ Donation 5 ☐ Other (Specification of Figure 1) Property of Figure 1. Signa are of Figure 1.	*	Crem				2011		, Maryland
Departition of the control of the co	1	) the let	/	1619	755	ert A. Pun 7 Wiscon	phrey Tun nsin Ave	eral Home, nue, Bet	Bethesda-Ch hesda, Ma	evy Chase, Inc. ryland 20814
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused ne cause on each line	the death.	Do not enter	the mode of dying	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Breast							Onset and Death
Examiner		Todaking in doubly	Due to (or as	a conseque	nce of):					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	nce of):					
xecuted and al-transit	Examiner	Cause (Disease or impury that initiated events	C							
ciar ciar	dical E	resulting in death) Last	Due to (or as	a conseque	rice oi).					
<b>GOX 68 /6U</b> death certificate be the attending physical for use as the the forms of the the the forms of the	Medi		d							
X 68/1 h certificat tending ph rruse as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1  Live Birth	of pregnance 2  Fetal c	cy death 3 🗌	Ectopic pregnanc	у		23d. Date o	· .
box	Physician/Med	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	ath 5	Other (specify)			Month	Day Year
Kecords, F.O. The law requires that the ate has been signed by the page 2 should be detach	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not result	ting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
dS, quires en sign		Metasticies to h	one and 1	iver				1 🗆 🕆	Yes 2 No 3	Probably 4 🔀 Unknown
law re	Completed							24a. Was a	sy prior	autopsy findings available to completion of cause of
VITAI KECOTAS, ysician: The law requires is certificate has been sig		Of Was assessed as a section						1 🗆 Yes	rmed? deat 2 No 1	h? Yes 2 No
IVISION OT VICAL  or Attending Physician: after death. Director: After this certific Lin by the funeral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	ant 0 🗆 🗆	R/Outpatient	Othe	ace of Death (Che		o 127 ou	<sub>pecify)</sub> Hospice
OT ng Phy ter this neral of		27. Manner of Death	28a. Date of inju	ry 2	8b. Time of injury	28c. Injury work	at	1	ow injury occurred	респу) ПОВРІСС
tendir death. tor: Af the fu	Certificate:	1 XX Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 No			
DIVISION tal or Attendir rs after death. al Director: Afed in by the fur	Cerl	4 Homicide determined	28e. Place of Inju building, etc	iry - At hom c. (Specify)	e, farm, stree	t, factory, office		28f. Location (S City or Tow		Rural Route Number,
LIVISION OF VITAL RECC To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phys								
the H thin 24 the Fu	Med	only one) 3 Certifying Nurs				ath occurred at the	time, date and p	lace, and due to the	e cause(s) and manne	
6 ≥ 6 8		29b. Signature and title of certifier	miolas	) / [	> ND	29c. License R1432			29d. Date signed (M	ontn, Day, Year)
7		30. Name and address of person who c	ompleted cause of d	eath (Item 2	3a) (Type, Pri		.01		10/01	111
1		Deborah Miller, (					l, Rockv	ille, Ma	ryland 20	855
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 2 20	32 Registra	ar's Signatur	. pa	Kel				
31011		1101 0 2 20	11 Color	~ 10	. /9					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24, 11:00 P M Charlie 2011 Bowman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring 9117 Flower Avenue Montgomery Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under **Funeral** 403-60-8706 Director 1 X M 2 □ F 68 September 21, 1943 Kentucky 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Silver Spring Montgomery 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9117 Flower Avenue 20901 United States items death 12. Was Decedent Ever in U.S. Armed Forces? unk 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or δ 1 X Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Divorced Specify: Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 is and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Nuclear Plant Draftsman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Irvin Bowman Lucy Sames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 705 New London Road, Hamilton, Ohio 45013 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Lucy Ellen Jones/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State October Memorial Gardens Manchester, Kentucky 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Fund yal Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part / Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Cardiovascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause, Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death ☐ Unknown g Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires Hypertension, Hypercholesterolemia, Human 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Immunodeficiency Virus 24a. Was an cate has autopsy performed? Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 2 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide n 24 hours after death Le Funeral Director A pletely filled n by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined cal 29a. Certifier X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the l within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Do051963 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Derje Woretta, MD

NOV 0 2 2011

31. Date filed (Month, Day, Year,

Registrar's Sign

12201 Plum Orchard Drive, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ SCOY 24.20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, **Examiner** Town, or Location of Death 4c. County of Death HOOKins Hospi Ohn 7. Age (In yrs. last b Funeral 8. Date of Birth 9. Birthplace (State or Foreign 581-67-1940 Months 48 05/28/1963 Couptry erto Rich Director 1 M/ 2 | F 28a-f shov 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 X Yes 2 No 10e. Street and Number 4002 Marx Avenue 5 10f. Zip Code 21206 10g. Citizen of What Country? Funeral **23**a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0. by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 SpecWhite 1X Yes 2□No Specify: Puerto Rican "natural", Completed 3 - Widowed 4 - Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Security Service quard traumatic event, Be 17. Father's Name (First, Middle, Last)
Jose Berrios Vazquez 18. Mother's Name (First Middle, Maiden Surname) Maria Milagros Santos 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4002 Marx Avenue, Baltimore, MD 21206 Martha E. Berrios Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth once. Date 20c Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Chesapeake Crem. 10/27/201 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Marshall 22. Name and Address of Facility Cremation Service P0 box 1413, Baltimore, M 21. Signature of Funeral Service License 0000 a e s M D 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) as a consequence of): Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be ( 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 20 No Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 2 🗆 No Investigation M 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number WIC Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

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31. Date filed (Month, Day, Year)

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North

2. Registrar's Sigr

MOLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Walter C. Covington Oct 29, 2011 8:10a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death **Baltimore** Towson Gilchrist Center for Hospice Care Sex Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday. Min. (Month, Day, 220-36-2750 70 Aug 28, 1941 NC **Director** 10a. State 10b. Count 10d. Inside City Limits aţ 10c. City, Town or Location Director notified 28a-f **Baltimore City Baltimore** 1 Yes 2 No ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 21239 1322 Crofton Road U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

X Yes 2 No8/23/1960 Black, White, etc. ö þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Black "natural", 3 Widowed 4 Divorced 8/21/1964 Specify: Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Salesman **Baltimore Sun Paper** 12 event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ever ည Willie Mae Covington Oscar Covington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Covington 1322 Crofton Road Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov 03, 2011 Crownsville, Md. **Crownsville Veterans Cemetery** 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Signa - et uneral Service License er the disease, or complications that caused heart failure. List only one cause on each line. Approximate shock, or heart failu Immediate Gause (Final Interval Between and Death Ph<sub>sician/</sub> disease or condition resulting in death) Medical Due to (or as a cons, quence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death, Funeral Director: After this certificate has been signed by the attending physician and burial-transi that initiated events resulting in death) Last Due to (or as a consequence of signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery lor i 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မှ 1 Tyes 2 L No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. / Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and 29c. License numbe 29d. Date signed (Month, Day, Year) Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARIS

State

Registrar

31. Date filed (Month, Day, Year)

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32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 201<sup>Yea</sup> 31<sup>ay</sup> 11:30 AM Kenneth A. Cox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 5836 Marbury Road Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Days Hours 532-22-3616 Director 1 X M 2 D F 94 December 7, 1916 Kansas Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No <u>Maryl</u>and Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 5836 Marbury Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 2 NoWWII/ 1 Never Married 2 Married ģ Yes Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates Korea other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working id Mental Hygiene. marked other than College (1-4 or 5+) 5+ Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) Communication Law Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jean Sears Seth L. Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5836 Marbury Road, Bethesda, Maryland 20817 Nona F. Cox / Wife altimore, 20b. Place of Disposition (Name of Montgomery or other place) Crematorium, Inc. 20a Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State November 2, 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Si nature of Fune al Servi Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase 20814 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death years Immediate Cause (Final Physician/ End-Stage Congestive Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Coronary Artery Disease with Myocardial Infarction 17 years Seudentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 as the t IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Disease Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available 24a. Was an Severe Lumbar Spinal Stenosis autopsy performed? Yes 2 X No prior to completion of cause of death?

1 Yes 2 No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗭 Residence 6 Other (Specify) Hospital: ပ 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

 Hospital or Attending Physician: The law 1 24 hours after death.
 Funeral Director: After this certificate has t **Division of Vital** completely filled in by the funeral To the within 2

Medical

29a. Certifier

only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore Li, M.D. 3301 New Mexico, N.W., Washington, D.C. 20016 31. Date filed (Month, Day, Year) NOV 0 2 2011

3 [

32. Registrar's Simature

Registrar

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

14603

29c. License number

29d. Date signed (Month, Day, Year)

November 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral Director	5. Social Security I		6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days		Hrs. 8. Date of B	irth(MM/DD	Fore	Birthplace (State or eign
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Baltimore, permit. Pages la Department of He Important: If ite injury or other tr	4 Donation 5			M		REMATORY		1/1/11		0., MI	
Bal Dermi Depar Impo	21. Signature of Fu			lan		ame and Address 701 LAUR					ONS F.H., INC
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			mined (Specify)	-f1111							
To the Ho within 24 To the Fu complete!	(Check only one) 2	Medical Exa	nysician: To the best miner:On the basis o	f examination and	e, death occum d/or investigation	ed at the time, date on, in my opinion,	e and place, ar death occurred	nd due to the cau I at the time, date	se(s) and ma and place,	anner as sta and due to ti	ted. he cause(s)
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hard	after	_ Bro	esself M	(D)		O.C.M	1.E.		Octobe	er 30, 201	1
or por	30. Name and address Melissa Bras		who completed cause Assistant Med	•		Baltimore Str	reet Baltim	ore MD 343			
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23a. Part 1. Enter shock, or he	r the disease, or complications that caus eart failure. List only one cause on each li	ed the death. Do not enter the mod	de of dying, such as cardiac	or respiratory arrest,	0 130 2	Approximate Interval Between
Physician/ Immediate Cause disease or condit resulting in death	e (Final tion a. RESP II	RATORY FAILU				Onset and Death
Examiner Sequentially list of	SEP.S	s a consequence of):			8	5 MONTHS
if any, leading to	immediate Due to (or a lerlying	s a consequence of):	01			6 MONTHS
0 = - 1 - 1	nts c.	TILATOR ASSO	CLATED PNE	MMONIA	,	
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death  Within 24 hours after death  Within 24 hours after death  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death  To the Funeral Director: The law requires that the death certificate be sometimed by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director.  Medical Certificate:  A Completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director.  A Completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director.  A Completely filled in by the funeral director.  B Completely filled in by the funeral director.  A Completely filled in by the funeral director.  B Completely filled in by the funeral director.  A Completely filled in by the funeral director.  B Comple	d					
Sox 68760  Reath certificate by a sattending physic of for use as the b in the bast 12 1	nt pregnant 23c. If yes, outcom	e of pregnancy			23d. Date of delive	erv
Division of Vital Records, P.O. Box 68760  Bal or Attending Physician: The law requires that the death certificate is after death.  In law requires that the death certificate be safer death.  In law the funeral director, page 2 should be detached for use as the learn on the funeral director, page 2 should be detached for use as the learn on the funeral director.  In Certificate: To Be Completed by Physician/Medical Certificate in the last of the last	No 4 Pregnant	2 Fetal death 3 Ectopic at time of death 5 Other (s)	pregnancy pecify)			Day Year
PO. Bes a contraction of the declaration of the dec	ificant conditions contributing to death			23e. Did tobacco	use contribute to th	e cause of death?
2, vening gen sign Neuron	LYEUTIS OPTICA,	DIABETES MA	LUTUS,	1 🗆 Yes 2	No 3 ☐ Prob	pably 4 🔀 Unknown
e law r	ENGON, QUADRI	PARESIS, C. DIFF	COUTIS	24a. Was an autopsy performed?	24b. Were autop prior to cor death?	osy findings available impletion of cause of
T	red to medical		26. Place of Death (Chec	1 Yes 2 🔼		2 🗌 No
Physical direction of the physical direction	ı ızı ınpa	tient 2 ER/Outpatient 3 De		ome 5 Residence	6 ☐ Other (Specify)	
Sion of death.  The full cate of Dea and Dea a	th  5 Pending Investigation  28a. Date of inj (Month, Di	ury 28b. Time of 29, Year) injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred	
Division of Vital Recompliance of the Hospital or Attending Physician: The law within 24 hours after death.  To the Hospital or Attending Physician: The law within 24 hours after death.  To the Hospital or Attending Physician: The law within 24 hours after death.  To the Hospital or Attending Physician: The law within 24 hours after death.  Medical Certificate: To Be Completely filled in by the funeral director, page 2 and provided the completely filled in by the funeral director, page 2 and provided the complete of the	6 Could not be 28e. Place of In	jury - At home, farm, street, factory cc. (Specify)		28f. Location (Street ar City or Town, State		Route Number,
Sprital hours a hours a hours a hours a hours a land a lan	1 E Certifying Physician: To the best o	f my knowledge, death occurred a	t the time, date and place a	and due to the cause(s)	and manner as state	24
The Hospita hin Further Hospita hin Further Hours hin a Check (Check only one)	2 Medical Examiner: On the basis of 3 Certifying Nurse Practitioner: To the basis of the basis o	examination and/or investigation in a	my opinion, death occurred :	at the time, date and place	e and due to the cau	ea(e) and manner etated
P ₹ P 8	) () [ A	BB S 290	License number		ate signed (Month, D	**
30. Name and addi	ess of person who completed cause of	death (Item 23a) (Type, Print)	BALTIN	WRE, MO.	21215	8 2011
Dr. ASHT	AMI BANAVALI,	SINAL HOSPITA	L OF BALT	IMORE, 24	+OIW BED	VEDERE AVE
State State Registrar	9V 0 2 2011 22. Registr	ar's Signature				

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 29, 2011 HARRY RAYMOND DeMOSS, JR. 11:40 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OAK CREST VILLAGE HEALTHCARE CENTER Parkville Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Months Days Hours Director 212-03-4339 90 Maryland Jan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Maryland Baltimore County Parkville 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8830 Walther Blvd, #126 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Insurance Industry Insurance Agent Be 17. Father's Name (First, Middle, Last) DEMOSS 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Raymond DeMoss, Sr. Foy 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important; If item 27 is m any injury or other traum once, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela K. Mitchell (Daughter) 1609 Alston Road, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 11/3/2011 4 Donation 5 Other (Specify) Baltimore, Maryland Sign/le of Fut I S Lick co. ever 2 Name and Address of Active MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, sading to immedicause. Enter Underlying Cause (Disease or linjury Due to lor as a donsequence of Exam or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant Pregnant at time of death 5 Other (specify) Month Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖭 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0030972

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State

Registrar

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ise of death (Item 23a) (Type, Print)

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Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 34860 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month (0 Physician/ Benita Day 30 Estrada žoli 2210 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Dama Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Hours 220-11-6075 77 march<sup>a,</sup> 27, 1934 <sup>c</sup>cuatemala Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 X No HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 W. FARROW COURT 21014 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 X Yes 2 □ No Specify: GUATEMALAN 3 Widowed 4 Divorced Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 LABORER DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked N/A and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 MARISA ROHRBAUGH/GRANDCHILD 805 W. FARROW COURT, BEL AIR, MARYLAND 21014 Department of Health Important: If item 2: any injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Page 1 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State BAYVIEW CREMATORY 11/7/11 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND Signature of Funeral Service Licensee Name and Address of Facility
POT EASTERN AVENUE , BALTO, MD 27231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ septic shock Medical resulting in death) Due to (or as a consequence of): **Examiner** oneummia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown o ריינים עוויס בפרנוזוכמנפ has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law After this certificate has autopsy perforn death? 2 No 1 Yes Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ပ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) of 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendîng Division 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D69196 30/2011 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) Tolie Fifer my Drive Bel Air, MB pper Chesapeake 500 31. Date filed (Month, Day, Year, State NOV 0 2 2011 Registrar

DHMH 17 Rev 7/2009

MECO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 3486 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:00 A M Physician/ owanda Arneva Greenhill 10 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** more ranklin Square Bait: HOSpital Kosedale 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Year) (Month, Day, 219.82.1362 1 🗆 M 2 🔀 F MD **Director** 12/30/1976 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State with the Maryland Director Baltimore 1 Yes 2 No Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or Funeral USA 21237 8750 Jarwood Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: Black. "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important; If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) College (1-4 or 5+) Assisted Living Supervisor 4 years 12th grade Be 8. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) L. tow Kes ည Esther Arthur S. Jackson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8750 Januard Road Rosedale MD Mother Greenhill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Windsor Mill, MD King Memorial Park 11/05/2011 4 ☐ Donation 5 ☐ Other (Specify) Vaugn C. Eveene Funeral Services 22. Name and Address of Facility Signature of Funeral Service Licensee 8728 Liberty Road Randallstown MD 21133 Vaugh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Obstruction Cause (Disease or injury that initiated events resulting in death) Last mal bowe attending physician and Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) ☐ Pregnam. ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No hours after death.

uneral Director: After this certificate had filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 \( \text{Yes} 1 Mnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5  $\square$  Pending 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral L Hospital Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

131

Registrar DHMH 17 Rev 06-2011 only one)

29b. Signature and title of certifier

NOV 0 2 2011

Yulinozhano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D70605

Franklin Square Drive

29d. Date signed (Month, Day, Year)

Baltimore, mo

October, 30, 2011

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lelinda Ann Gon		orate of maryland, bopartmont of floatin and mont	tal Hygiene	201	1 34862	
Physicia		1- For State  Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of D	Reg. No.	3. Time of Death	
Medical Examir	-	Melinda Ann Comerinaer		Day Year 31, 2011	1202 hrs	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location or  8010 Upperfield Lane  Owings Mills		4c. County of Deal Baltimore Co		
Funeral				Birth(MM/DD/YYYY) 9. Bi		
Director		220-60-9123 1 M 2XF Yrs. Months Days Hours Usual Residence of Decedent	Min. Augu	st 2, 1964 Fore	ountry) MD	
Any	ŀ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
Maryland 28a-f show	ē	MD Baltimore Owings Mills	5		1 No	
hours after death with the Maryland "natural", nr items 23a or 28a-f sho Examiner must be notified at once.	Funeral Director	10e. Street and Number		10g. Citizen of What Cou	untry?	
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death	E L	1 Never Married 2 Married Armed Forces?  If Yes, specify Cuban, Mexican,		White, etc.		
s after	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give k	dad at wale days	Specify:	<i>uhite</i>	
2 2	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)		16b. Kind of Business	Industry	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be Co	D : 1 E 1 : V C	s Name (First, Middle	e, Maiden Surname)	Mac	
			ber or Rural Route N	lumber, City or Town, Stat	e, Zip Code)	
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ore, M ges 1 and 2 of Health If item 2 ther traun		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Dateunk	20c. Location - City-o	r Town, State	
	-	4 Donation 5 Other Specify: Creenut Vent VIII 21. Signature of Fundal Service Licenspe 22. Name and Address of Facility		Allentaer	1) PH	
Balti permit. Departi Import injury		Clever haveh TAM 1232 N	Aidvella.	Dr. Jess	OP PA	
Physician /Medical	T	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.	ardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and	
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		Sequentially list conditions,  b				
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Physical direction	위	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4  27. Manner of Death  28a. Date of Injury  28b. Time of Injury 28c. Injury at Work?	Nursing Home 5	Residence 6  Other	er: Scene	
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or A of A Direction by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	c. 28f. Location	(Street and Number or R	urat Route Number, City	
ospital hours neeral	- S	4 Homicide determined (Specify)  29a. Certifier , Cartified Physician Table based (Specify)				
To the Hospital within 24 hours a To the Funeral completely filled	10	(Check only one) 2 Windical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)		• • •		
<b>6 3 6 9</b>	¥ -	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	onth, Day, Year)	
		Panelifrenthall, M) O.C.M.E.		November 1, 20	11	
31		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore MD	21223		
Sta	ate	31. Date filed (Month, App) (20)	Daiminole, IVID			
Registr		NUV U 2 2017 Clever B. Jacker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gladden D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mad son Avenue 1606 East If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 212-78-5466 43 1 🗆 M 2 💢 F Director MP 09/3/68 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Batimore 1 Yes 2 ☐ No MID 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 21205 USA 1606 Madison Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced African-America other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmast. College (1-4 or 5+) Elementary/Secondary (0-12) Secretary Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Jones Gladden ElDISE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jones / Daughter Madison Baltimore Aunjanae 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
t. Carmwl Cem 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt.,MD 11/5/11 Mt. 22. Name and Address of Facility Hari P. Close F. Sys, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service icensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sudden Ph\_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine trans, feating to framed cause. Enter Underlying Cause (Disease or injury burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has have circular to the Funeral Director. signed by the attending physician and id be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🗌 No 1 X Yes 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Medical Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 \( \text{Yes} 2 🗌 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The trigging mysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D6298 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hand hry 4940 Eastern MD Hmina Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 2 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 26 Physician/ Jasper B. Grady OCTOBER 2011 8:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Birthplace (State or Foreign Country)
 NC Social Security Number 8. Date of Birth (Month Day, 1928 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1**X** M 2 F Months Days Hours 241-32-1409 83 Director Usual Residence of Decedent 10d. Inside City Limits 1 Yes 2 No 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland **Funeral Director** or 28a-f sl notified **Baltimore** MD **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r 21216 U.S.A. 4118 Fairview Avenue items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o, Ď 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black "natural", Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Manager (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **US Postal Service** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Erma Grady Maxwell Grady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4118 Fairview Avenue Baltimore, MD 21216 Isabelle H. Grady of Health If item 27 20a. Method of Disposition

Disposition

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Veterans 20c. Location - City or Town, State Date ò Nov 03, 2011 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Farmeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Lice Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Directo for selector enough on uni-If any, leading to immediate cause, Enter Underlying Physician/Medical Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Natural N 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month/Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Jasper

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER <sup>D</sup>20 2011 733 7:33 A M **GAFFNEY JACQUELINE** YVETTE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 MONTGOMERY ROCKVILLE SHADY GROVE HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Hours 1 M 2 X JUNE 30 INDIANA 53 "1958 Director 212-74-5756 1105/20/01 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No POTOMAC MD MONTGOMERY 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ò and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be I Funeral 20854 USA 9411 NEW BRIDGE DRIVE queline 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 K No Specify. If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Jac College (1-4 or 5+) Elementary/Seconday (0-12) SPECIALIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 SMITH ELBERT GAFFNEY WILLIE MAEWALLACE injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra 9812 FALLS ROAD POTOMAC, MARYLAND 20854 GAFFNEY/SISTER LISA 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State MD NATIONAL CEMETERY 10-26-11 LAUREL, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBAL 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ire. List only one cause on each line Onset and Death Immediate Cause (Fina Physician/ Gastrointestina disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ions of Gastric Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi and that initiated events Due to (or as a consequence of). resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 L Yes 2 D q 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Obesity 1 Yes 2 No 3 Probably 4 Junknown Morbid Completed 24b. Were autopsy findings available prior to completion of cause of death? Hy potension has autopsy performed? Anemia 1 ☐ Yes 2 🖾 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Hospital: ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred work?
1 Yes 2 No injury Natural 5 Pending Accident
Suicide Investigation 6 Could not be To the Hospital or Atterviewithin 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bullane MO DDO 66654 21,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical 9901 Fak M 31. Date filed (Month, Day, Year) 0CT 2 4 2011 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** STEVEN **JEFFREY GROSS** )ctober 2011 /Medical 4a. Facility Name (If not institution, give street ap 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year 8. Dale of Birth (Month, Day, more 5. Social Security Number Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ 57 Yrs. 214-66-6512 Director 07/25/1954 MD SVEN Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maxical Ext. upper must be recitified at once. 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1814 RAMBLING RIDGE ROAD, APT. T-1 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_2 MNo If Yes, Give ' Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) KNOWN College (1-4or 5+) Elementary/Secondary (0-12) MANAGER PRINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WILLIAM **GROSS** ETHEL 711SK TN 19a. Informant's Name/Relationship (Type. Print) PERSONAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 NORTHWAY. BALTIMORE, MD 21218 BRYAN H. POTTS/ REPRESENTATIVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1)CXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PK. 10/30/2011 RANDALLSTOWN. 21. Singly of Funeral Service Lives e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or competations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s performe 2 No 1 ☐ Yes 2 No 25. Was case referred to medi a funeral director, 26. Place of Death (Check only one) examiner? 1☐ Yes 2☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation n 24 hours after death.

e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA no

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 0 2 201

\$2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Edward Henderson OCIORS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Raltimore Baltimore HOSpital Dinar cial Security Numbe 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 213-28-5038 1 XM 2 - F 80 Yrs 03 02 31 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director MD James Henderson NA Baltimore 10e. Street and Number 10g. Citizen of What Country? with 1 Funeral U.S.A. 2602 Rosewood Ave 21215 "natural", or item ledical Examiner n 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black Completed 3 🔀 Widowed 4 🗌 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade Mill Worker Bethlehem Steel Be Panent Known as 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Henderson Ola Wooden of Health and I item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Christina Speight-daughter 2602 Rosewood Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Murial 2 Cremation 3 Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 11/5/2011 Arbutus, Md 21. Si ma ufe of Funeral Service Ligensee 22. Name and Address of Facility March F/H West Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Acute myoccord Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events physician and strans the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 nding p. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for us 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus typeII, Hypertosion Completed 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Arterial Disease 24a. Was an has performed? Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how Injury occurred 1 Natural 5 Pending neral Director: A rilled in by the f 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely fi Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

02:25PM

MD

10d. Inside City Limits

21215

Day

Interval Between

Onset and Death

1 XYes 2 No

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Ellen Hartson 2011 12:20 A. M October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Long View Nursing Home Manchester . Social Security Number Funeral If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2XXF Hours (Month, Day, Ye Months Days Min. Country) Maryland **Director** 218-14-4620 88 Yrs. Nov. T922 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits Maryland 1 Yes XX No Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States of America by Funeral 1176 Larkspur Road 21157 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 0. Black, White, etc 1 Never Married 2 Married and 2 should be filed within 72 hours after thealth and Mental Hygiene. Maryland 21215-0036 1 ☐ Yes 📈 No Specify: If Yes Give Completed 3XXWidowed 4 □ Divorced Specify: White Year or Dates th and Mental Hygiene. ?7 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) llth Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Somers Keating Naomi Elizabeth Colehouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Craig Hartson (Son) 223 Hideaway Drive, Westminster, Maryland 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5XX other (Specify) Entonoment Woodlawn Cemetery Nov. 4, 2011 Woodlawn, Maryland 21. Signature of Funeral Perfee Ligenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 ent/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition reard Medical resulting in death) Due to (or as a consequence of): Examiner 13chew Sequentially list conditions, if any leading to immediate cause. Enter Underlying Que to for as a nonseque los V sician and burial-transit Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 1 ☐ Yes 2.2 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been signated bage 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate perfor death? 1 Yes 1 Yes 2 No e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifics leted filled in by the funeral director, p Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work 1 Yes 2 🗌 No Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical TE Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Octobe 03287 3/1 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 Spell MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Toto ber Physician/ Alice L. Johnson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b\_City, Town, or Location of Death Examiner Stimure N/A Greneral mRy land 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral 1 □ M 2 🔀 F Months Hours 0974 74 1914 Maryland 214-18-1846 Director 97 Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10a. State 10b County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director ¹y Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21217 2809 Parkwood Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, ıral", or iten I Examiner r ביב-עב should be filed within 72 hours after de ith and Mental Hygiene. 27 is marked ביב Black, White, etc. Be Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) self housewife 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Levy Bessie Smith pe 1 and 2 should be tof Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 Edgemont Ave., Baltimore, MD 21217 Nathaniel Freeman(son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ot 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/07/11 Baltimore, MD woodlawn Cem. formandadassof Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, I 21. Signature of Funeral Service Licenses MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final disease or condition FIBRILLAtion HRIAL Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) rabetes Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury the burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of attending physician Physician/Medical I Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year ed by the a detached t 1 ☐ Yes 2 ☐ 9 ☐ Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ease, thrombouttopenia 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate 2 🗀 No Yes 2 W No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signatur and title of certifier dup 10/30/2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Paryland

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State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 2

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#11perINF, 6922, 127 672011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar 34870 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shar MALACHI JONES JR 1229 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 500 NORTH HARRY S. TRUMAN LARGO PRINCE GEORGE'S Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ₹ M 2 □ F Hours Min. Months 78-56-7842 *376,7*3,346 WASHINGTON DO 65 Yrs. Director Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD PRINCE GEORGE'S LARGO 1 A Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 NORTH HARRY S. TRUMAN DR 20735 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK "natural", 3 Widowed + X Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ENVIROMENTAL SPECIALIST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ MALACHI JONES SR ANNALEE LOMAX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau KAREN JACKSON/ DAUGHTER PURPLE LILAC LANE CLINTON MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREM. 11/1/2011 BELTSVILLE, MD 4 ☐ Opnation 5 ☐ Other (Specify) 21. Sig at f Funeral Service Liceur 22. Name and Address of Facility CAPITOL MORTUARY AVE NE WASH 23a. Part 1. Enter the diseast shock, or heart failure ath. Do not enter the mode of dying, such as cardiac or respiratory arrest or complications that caused the t only one cause on each line. Immediate Cause (Final Contiones colon Discon ath Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Se unitally let any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Box 68760 the attending p IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No the 9 Unknown Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 X No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) completed filled in by the funeral director xaminer? Hospital 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) To the Hospital Medical 29a. Certifier Cortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who c ed cause of death (Item 23a) (Type, Print 3001 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 10 5:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 0 uns. . Age (In yrs. last bjfthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Hours (Month, Day, Year, Director 579-24-2191 87 192 Wash Ian Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🙀 Yes 2 □ No Laurel Prince George's Md 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 20707 United States 13551 Belle Chase filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. o 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 XWidowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Police Officer Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Etal Jacobs Richard Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Jay Court Glen Burnie, Md. 21061 Pericles Jacobs, Jr/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Lincoln Cem. 11-1-11 Brentwood, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Capitol Mortuary, HARVER NE Maryland Ave. 23a. Part 1. Enter the disclass or complications that caused the de 4h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an was autopsy performed? cate has 2 XNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natural Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗀 Yes 2 🔲 No Certificate: 28d. Describe how injury occurred 5 Pending Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0071145 30. Name and address of 5755 CEDA LANE COLUMBIA, MD  $^2$ 1044 CEDAR 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State

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_			30. Name and address  JACKIE JO	NES, CE		e of death (Item  O DULAN			<i>/</i> ' − '	TIMO	NIUM,	MD 21	093				
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		1- For State Registrar		rtificate of	Death		Reg	g. No.	: 0401
Physici Iedical Exami		1. Decedent's Name (First, Middle,Last)			-		2. Date of Death	Day Year	3. Time of Death 0730 hrs
		4a. Facility Name (if not institution, give 2604 Holly Beach Road	street and number)	41	Essex	or Location of Deal	th	4c. County of Dea Baltimore Co	
Funeral Director		5. Social Security Number 6. Sex 214-22-7940		last birthday) 84 Yrs.	If Under 1 Ye Months Da		_	1,1926 Fore	
Aaryland 28a-f show any 1 at once.	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Balti  10e. Street and Number		r, Town or Locatio	n 10f. Zip Code		110	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	I Director	2604 Holly Be	each Road			221	10	USA	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sha injury or other traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No fYes, Give Year or Dates:	If Yes	s, specify Cuba res 2 🔀 N		o Rican, etc.)	White, etc. Specify: Wh	erican Indian, Black, ite
5-0036 led within 72 hour: Hygiene. tother than "natu	Completed	15. Decedent's Education (Specify only Elementary/Secondary (0-12) 10 th	College (1-4 or 5+)	during mos			tired)	16b. Kind of Business Paper Ha	,
15-C	Be Co	17. Father's Name (First, Middle, Last)  John Koval				1	e (First, Middle, Ma s Brock		
MD 21215-003 12 should be filed within th and Mental Hygiene. 127 is marked other thumatic event, the Med	ToB	19a. Informant's Name/Relationship (Typ Charles Kæf)				eet and Number or	Rural Route Numb	per, City or Town, Stat	te, Zip Code) e MD 21221
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		20a. Method of Disposition  1 X Burial 2 Cremation 3  4 Donation 5 Other Specify:	Removal from State	Place of Dispositi crematory or othe	on (Name of co	•	Date	20c. Location - City of	
Balti permit. Departm Importa injury o		21. Signature of Funeral Service License			me and Addres	ss of Facility 30	0 Mace	Ave. Bal	to. MD Ssex 21221
Physician /Medical £xaminer		23a. Part I. Enter the disease, or complic failure. List only one cause on each Immediate Cause (Final disease a. A.	tations that faused the death in line. therosclerotic Cardiov		mode of dying	g, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
		Sequentially list conditions, b	ue to (or as a consequence o	<i>'</i>					•
	Examiner	(Disease or injury that initiated	ue to (or as a consequence o	_					
760, cate be executed physician and the burial - transit		d.		···).					
760, icate be ex physician the burial	Medical	UNPENDED	AMENDED	nanou				Tool Baratas	
eath certifications attending	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of preging the Live birth  Pregnant at time of de given unknown	2 Fetal	death 3	Ectopic pregn	ancy	23d. Date of delive Month	ry Day Year
P.O. es that the gned by	Š	Part II. Other significant conditions co	ontributing to death but not re	esulting in the und	derlying cause	given in Part I.		acco use contribute to	the cause of death?
Division of Vital Records, P.C tal or Attending Physician: The law requires that is after death.  al Director: After this certificate has been signed the in by the funeral director, page 2 should be detain	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	a	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	EDIO 1 - 1 - 1	-	e of Death (Check			
on of Vit nding Physia th. :: After this e funeral din	ion: To	1 ✓ Yes 2 No  27. Manner of Death  1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of Inju	ury 28c. Inju	Other Nursing Nursing at Work?  Yes 2 No		esidence 6 🗸 Othe	er: Scene
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, street,	factory, office	building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	one) 2 Medical Examiner:0	: To the best of my knowledge the basis of examination and manner stated.						
F > F &	Me	29b. Signature and title of certifier	uD		29c. Licen	se number .M.E.		29d. Date signed (Mo	
		30. Name and address of person who con Laron Locke MD. Assistar	mpleted cause of death (Item nt Medical Examiner	•	imore Stree	et, Baltimore,	MD 21223		
St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 2 2011	32. Registrar's Signatu	ire Land	,				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER DAVID 2011 KILBERG 2:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 218-03-9965 Director 1 XM 2 □ F 93 01/25/1918 MD 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD N/A BALTIMORE ms 23a or must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3021 FALLSTAFF ROAD, APT. 503 21209 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify Completed 3 ▼ Widowed 4 □ Divorced Specify WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COMMERCIAL REALTOR REAL ESTATE of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HARRY KILBERG KATIE POLANSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12095 LONG LAKE DRIVE, OWINGS MILLS, MD ROBERT KILBERG/SON Department of Healtl Important: If item 2: any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State HILLTOP SERVICE CORP; 10/28/2011 4 ☐ Donation 5 ☐ Other (Specify) TOWSON, MD 21. Signature of Juneral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NI disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death 2 🗆 No the Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autops death? after death.

Director: After this certificate 1 Yes 2 No Yes 2 Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) finer? 1 Yes Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month. Day, Year)

NOV 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Leonard Kelley, Jr. Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton PG Funeral Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/16/1933 Hours 277-30-6668 **Director** 1**X** M 2 □ F 78 Ohio or 28a-f show 10b. County 10a. State must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD PG District Heights 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 7420 Marlboro Pike 20747 USA death w 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Yes 3 Divorced 1 ☐ Yes 2√2 No Specify: Completed Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygieses Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leonard Kelly, Sr. Estelle Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Kelley III, (son) 2300 Good Hope Road #615; Washington, DC 20020 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Western National Military Cemetery 4 Donation 5 Other (Specify) 11-4-2011 Akron, Ohio o Funeral Service Licensee Signat 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road: Temple Hills, MD 23a. Part (. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 5 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de-Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner?

1 Yes 2 No To Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending of the state of th Accident Investigation 1 🗌 Yes 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hours to the Fune completely fi (Check only one) 29b. Signature and 29c. License number M D0055120 30/Name/and address of person who completed cause of death (Item 23a) (Type, Print) 0 Suck 310 MI) 1328 Southern avenue almer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month KAPLAN IRIAM 201101:30 P 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/AIf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 □ · 081-01-9000 Director 93 02/01/1918 NY Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 28a-f show at notified Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code pe a is 23a must f 1500 BEDFORD AVENUE, #206 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ral", or iten Examlner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced 'natural". WHITE Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) the HOMEMAKER OWN HOME other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Be ည SAMUEL FELDMAN SADIE FIDDLEMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1012 FOXCROFT COURT, WESTMINSTER, MD Department of Health Important: If item 27 any Injury or other tr once, BARRY KAPLAN/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) OHEB SHALOM CEM. 10/30/2011 REISTERSTOWN, MD 21. Sign/ture f Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performed certificate l 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Hursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1-Natural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

BABATUNDE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINI ALE

HYSICIAN

Mi

29c. License number

00064533

2434 W. BELVEDERE

29d. Date signed (Month, Day, Year)

AVE BALTIMORE MOZILIS

a GRIATRIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2:07 A M 2011 RITA С KATZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE CARE TOWSON Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year Hours Min. **Director** 1 □ M 2X F 218-14-6334 11/04/1923 NY 87 Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No MD BALTIMORE BALTIMORE 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5 POMONA WEST, 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event \*\*... (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SALES RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROTHMAN ABE SCHWARTZ ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 POMONA WEST, #3, BALTIMORE, MD JEROME KATZ/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 10/31/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part :—Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death be detached 9 Unknown 9 Unknow signed by Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ aure 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 🗌 Yes Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 ☐ Yes 2 ☐ No 5 Pending injury Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DUTOBER 28 201 who completed cause of death (Item 23a) (Type, Print) N. Courtes ST MANKS M 6701 31. Date filed (Month, Day, Year) State NOV O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G921 11/15/2011 III State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month NOSTROM JIVIAN MERRITT 1130 NOVEMBER 201 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 107 S. Linwood Avenue Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
11-1-1918 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 XF 442-12-3057 93 Director Oklahoma Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, if a Medical Eventral must be notified at MD 1 TYes 2 □ No Director Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 107 S. Linwood Avenue 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) In own home Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Merritt Minnie McClure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is any Injury or other trau 107 S. Linwood Ave., Baltimore, Maryland Bruce Merritt Lindstrom 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 Cremation 3 Removal from State Arlington National 1-04-2012 Arlington, Virginia \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service icensee 22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St., Baltimore, MD 21224 pu nter the diease, plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death e. ⊒st⊯niv shock, or he Immediate Cause (Final disease or condition resulting in death) **Physician** DEBILITY MONTHS /Medical Due to (or as a consequence of): Examiner EMENTA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home Sesidence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

and

attending physician

certificate

After this

within 24 hours after death To the Funeral Director:

To the Hospital or Attanding Physician:

1 and 2 should be filed within 72 hours after death with the Maryland

at Hygiene.

and Mental

Baltimore, Maryland 21215-0036

JENNIFER HAYASHI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

D62032

NOVEMBER

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5505 HOPKINS BAYVEEW CIRCLE BAITO., MD 21.224 egil trar's Signatu

29c. License number

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **Delores Laws** Oct 26. 2011 6:05a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Towson **Gilchrist Center for Hospice Care** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) (Month, Day, Year) Jun 25, 1935 Months Days 213-32-9886 1 🗆 M 2 💆 F SC Director 76 ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD **Baltimore Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7304 Windsor Mill Road 21244 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ð 1 X Never Married 2 Married 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates Black "natural", 3 Widowed 4 Divorced Specify: Completed permit. Page 1 and 2 should be filed within 72 hours Doppartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker **Private Homes** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Farl Laws Carrie Laws 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Squire 7304 Windsor Mill Road Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State Oct 31, 2011 Timonium, Md. **Dulaney Valley Memorial** 4 ☐ Donation 5 ☐ Other (Specify) Sign of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Part 1 Inter the disease, or complications that caused the shock or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown signed by art II. Other significant condition ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Medical Certificate: To

the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 After this certificate has within 24 hours a

To the Funeral

death

Baltimore, Maryland 21215-0036

			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of Death (Check	only one)	
1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Hor	me 5 Aesidence 6	XOther (Specify) + 05Pl CP
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier 1 Certifying Physi (Check 2 Medical Examin	ician: To the best of my knowledge, death occurrence on the basis of examination and/or investigation	urred at the time, date and place, an	d due to the cause(s) and	d manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0071187

address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Chooles St. Suite 405, Baltimare, MD 21104

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2011 JOHN MCKINLEY LUNDY 10:26 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2203 ROSLYN AVENUE BALTIMORE 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Hours Mir 11-23-1926 228-28-9506 VA Director Usual Residence of Decedent show aţ 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sh notified a MD 1X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 2203 ROSLYN AVENUE # 103 21216 USA permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. Important If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

Yes 2 \( \square\) No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BETHLEHEM STEEL WEEDER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ SARAH JACKSON JOHN LUNDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24235 S. HALIFAX RD. JARRATT, VA 23867 MORRIS MITCHELL/BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 11-01-2011 BALTIMORE, MD **METRO CREMATORY** 21217 JAMES A. MORTON & SONS F.H., INC. Signature of Funeral Service Licenses 22. Name and Address of Facility 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Obstructive hronic disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine cause. Enter Underlying Due to (or as a consequence or, signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by A sbestosis 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital ြု 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 0035363 30. Name and a ho completed cause of death (Item 23a) (Type, Print)

State Registrar N. Greene St. Baltomore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lefkowitz Month Year 6:20 AM Octobe Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita alt more opkins N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours **Director** 077-40-6285 1 □ M 2 🗓 F 65 Usual Residence of Decedent 07/31/1946 HUNGARY s 23a or 28an connect be notified at 28a-f show 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Examiner must 3616 LABYRINTH ROAD 21215 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ő þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🕅 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Important: If item 27 is marked other than any injury or other traumation. Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ဂ DAVID STEINER CLARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HIRSH LEFKOWITZ/HUSBAND 3616 LABYRINTH ROAD, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) BETH ISRAEL CEMETERY 10/30/2011 WOODBRIDGE, NJ 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or and consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 M No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number RES-000 October 30 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaltimore MD 21287 Rod Rahimi (000.N.Wa) 31. Date filed (Month, Day, Year) State NOV 0 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2011	34882
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Physician		egistrar . Decedent's Name (First, N	fiddle,Last)	_		Ooranoa	10 01	Bouin			2. Date of De	Reg. No. eath		3. Time of	Death
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,	2	a. Facility Name (if not inst	tution, give				4	b. City, Town	, or Locat	tion of Death		4c. Cou	inty of Dea	ath	
		918 East 41 Street						Baltimor			T				
Funeral Director	- 1	5. Social Security Number	6. Sex		7. Age (In	yrs, last birth	day)	If Under 1 Months	-	Under 24Hrs. lours Min.	1	Birth (MM/DD/Y	Fore	eign	te or
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2121 ould be fi d Mental I s marked tic event,		George Mon				19b.	Mailing	Address (S		vie T		umber, City or	Town, Sta	ate, Zip Code)	
MD 3	-	Alex Berna			-Husk		18	East	41t	h str	eet,	Balti	more	, Md	21218
C G H 7		20a. Method of Disposition		7.0		20b. Place of cremator			cemeter	у,	Date	20c, Locat	ion - City	or Town, State	3
Baltimore, permit. Pages I an Department of He Important: If ite	- 1	1 X Burial 2 Crem 4 A Donation 5 Othe		_ Removal ti	rom State	Wood	-			11/	5/201	1 W00	dlaw	n, Mđ	l
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68760 certificate nding physise as the b	2	F FEMALE: 3b. Was decedent pregnant past 12 months?	in the	1 Live t		f pregnancy 2	Feta	al death	3 Ec	ctopic pregnar	псу	Mon	te of deliv ith	Day	Year
Box 68760 e death certificate the attending phys ed for use as the b	<u> </u>	1 Yes 2 No 9	Unknown	4 Pregr	nant at time	of death 5	Oth	er (Specify)							
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F Vita	ו מ	examiner? 1 ✓ Yes 2 No	Ho	ospital: 1	Inpatient	2 ER/Out	tpatient	3 DOA	Other	4 Nursing	g Home 5	Residence	6 🗸 Ott	her: Scene	
Division of Vital Records, to or Attending Physician: The law require at an effect of the above of the forest of the funeral director, page 2 should be attended.		27. Manner of Death  1 Natural 5		28a. Date	of Injury h, Day,Year)	28b. T	ime of In	'	Injury at \	(	28d. Describe Subject as	e how injury o	curred		
SiOr Attend death. ctor: y the f	<u> </u>		Pending Investigatio	Oct 24,	2011	1500	hrs		Yes 2		00/ 1	(Ot 1 N		Dural Davida A	lumban Oiku
Division ospital or Attending tours after death.  neral Director: After filled in by the fune for the filled or the fune for the forest or the fune for the forest or the			Could not be determined	e		- At home, far nouse / Ro			ce buildin		or Town,	(Street and N State) Street , Balti			umber, City
h bou		4 Minimizede							e, date an			use(s) and ma			
To the How within 24 h To the Funcompletely	3	Onder only	Examiner:		of examina							te and place, a			
To viti	<b>E</b>	29b. Signature and title of co		^ ^ ^			_		ense nun			29d. Date	signed (A	Month, Day, Ye	ar)
		Carol	Ht	U	acr			0	.C.M.E.			Octobe	r 25, 20	011	
12	1	30. Name and address of pe				(Item 23a) er 900 W	/ Roll	more Str	et Pal	timore Mr	21223				
Stat	(a) 3	Carol Allan, MD  31. Date filed (Month, Day;)			egistrar's S		. Daili		ot, Dal	annoid, IVIL					
Registra	~	NOV 0 9		1			all								

DHMH 17 Rev 1/2001 OCME 2006

OCME ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 55 AM Mallick Havat 2011 Atia Och Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34. Lospita Baltimore Agnes 5. Social Security Number Ukn If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) 1 □ M 2 🛣 F Months Days Director Pakistan Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County aţ 10a, State 10d. Inside City Limits death with the Maryland Director Examiner must be notified 1 Yes 2 No Owings Mills Baltimore MD 10f. Zip Code 10e Street and Number 5 10g, Citizen of What Country? items 23a Funeral 21117 Pakistan 1301 Kingsbury Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: <sub>Specify</sub>Pakistanian 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) House 12th grade Housewife na Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important. If item 27 is marked o any injury or other traumatic ever Anjumin Nisa Yunus Mallick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1301 Kingsburg Road, Owings Mills, Md 21117 19a. Informant's Name/Relationship (Type, Print) Atif Mallick-Son Baltimore, 20c. Location - City or Town, State
Millstone
Township, NJ 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Jersey State Memorial 10/31/2011 Donation 5 Cher (Specify) 21. Signeture of Funeral Service Licer 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21215 Baltimore, Ave. 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ o day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events espiratoe and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal dea ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Records, difease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? eetive 24a Was an has page 2 autopsy performed 4ilator certificate 2 🔀 No 1 Yes or Attending Physician: director, 25. Was case referred to medica of Vital æ 26. Place of Death (Check only one) examiner? Hospital Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 🗌 Yes မ 1 Nnpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division death. Investigation Accident within 24 hours after deat To the Funeral Director: completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 = Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and Atle 29c. License number 29d Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nitupouma Mithkits, MD St. Aprila Hosbital

MD

32. Registrar's Sig

Mitkies,

31. Date filed Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCH 25 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Northwest Hospital Hospice Ctr. Baltimore City If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **Director** 213-32-4908 1 □ M 2 **X** F 75 Nov. 10,1935 Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director MD Dunda1k Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7808 St. Gregory Drive 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 XN0 Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3X Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Baker Harry Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Rhonda Krisher (Daughter) 605 S. Eaton Street Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 10/29/2011 Towson, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses Puda-Ruck Funeral Home of Dundalk, Inc. 7022 Wise Ave Dundalk, Marvland 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ MONIA neu disease or condition Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 1 Yes 4 Nursing Home 5 Residence 6 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural work?
1 Yes 5 Pending 24 hours after death. Funeral Director: A 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou

To the Fune

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29b. Signature and title of certifie State NOV O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2019a Michael Charles Milburn October 29 2:00 Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 220-62-4792 03-02-1955 Mary Land **Director** 56 1 M 2 □ F Usual Residence of Dec 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** Baltimore N/A Maryland 1 X Yes 2 □ No 10g. Citizen of What Country? ö 10e. Street and Number 10f. Zip Code 21206 items 23a 5920 Greenhill Avenue 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify White Specify: "natural", 3 Widowed 4 N Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ad wn.
al Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steamfitter Pipe fitter and Mental Hygie is marked other other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname)

Maxine Holliday 17. Father's Name (First, Middle, Last) 0 Russell Charles Milburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Maxine N. Milburn - Mother 2827 Baurenwood Avenue Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Moreland Memorial Park 11-03-2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or co Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Yes 2 LN 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) nd title of Signature a 71046 29

Registrar

/ DHMH 17 Rev 06-2011

State

NORTH CHARIS

St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 0330 PM 2011 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death **FUTURECARE** CANTON HARBOR BALTIMORE N/A 8. Date of Birth 9. Birthplace (State or Form MARCH 15, 1917 MARYLAND 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 😾 F 220-48-5064 94 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show X□Yes 2□No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3406 DILLON STREET 21224 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 X No ģ Specify: WHITE 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file iment of Health and Mental Hi tant: If Item 27 Is marked oth Be Is marked **JOSEPH** GROCHOWSKI CHARLOTTE N/A19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ED MUSZEL/ 3406 DILLON STREET, BALTIMORE, MD permit. Pages 1 and Department of Healt Important: If Item 2' any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CROWNSVILLE V.A. CEM. 4 □ Donation 5 □ Other (Specify) 11/1/11 CROWNSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
LILLY & ZEILER INC. LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demen **Physician** TIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or impury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 2 1100 1 □ Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After (Month, Day, Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signa 29d. Date şigned (Mpnth, Day, Year)

State Registrar 30 Na

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 27, 2011 5:40 A M Jeannette Y. McNeill Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) Months Days Hours **Director** 199-10-3338 1 M 2 X F 94 Yrs January 10,1917|Pennsylvania Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Montgomery Maryland Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 9305 Hollyoak Court 20817 <u>United States</u> 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Victor Youngbluth Rose Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Patricia McNeill / Daughter 1819 Pamela Drive, Santa Rosa, California 95404 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery
Crematorium, Inc. Department of Important: If i any injury or o 1 D Burial 2 X Cremation 3 D Removal from State October 31 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fall from standing Medical resulting in death) Due to (or as a consequence of) Examiner Hip Fracture Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Dementia 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmonary Disease 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 🗌 Yes 2 🔲 No filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 10/23/11 1 Natural 2 X Accident 5 Pending 1 ☐ Yes 2 X No unk. Investigation Could not be Fall from standing 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Home 9305 Hollyoak Court, Bethesda, MD 20817 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D 6 8489 October 28, 2011 of person who completed cause of death (Item 23a) (Type, Print) 15 Timothy Bhattacharyya, 10215 Fernwood Road #506, Bethesda, Maryland 20817 M.D.

State

Registrar

31. Date filed (Month, Day, Year)

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			Registrar  1. Decedent's Name (First, Midd	ile, Last)	_		tincate or	Deatri		2. Date of Dea		<del>- U +</del>	3. Time of Dear	J J th
1	Physicia Medio	al		ETCHEN PAF		ER MIN				Month OC'				M
	Examin	er	4a. Facility Name (if not institution WRNMMC	on, give street and nun	nber)		4b. City, Town, 6	or Location HESD			4c. C	ounty of De MON	MONTGOMERY	
	Funeral Director	ĵ.	5. Social Security Number 226-44-7887	6. Sex 1  M 2  X F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min. 8, Date of Birth (Month, Day, Yes) October 18,			h (8 <sup>ear)</sup> 19	9. Birthplace (State or Foreign Country) Washington, D.C.		
		L	Usual Residence of Decedent  10a. State 10b. Count	lv		y, Town or Lo	ration						10d. Inside City Lir	
	farylan 3a-fsh tiffed a	Director		ntgomery	100.010	y, 10W11 01 E0		esda					1 ☐ Yes 2 🖁	
	a or 2	i Di	10e. Street and Number				10f. Zip Code				10g. Citize	en of What	Country?	
	h with	Funeral		ust Hill C				20814					States	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li><li>3 ☐ Widowed 4 ☐ Divorce</li></ul>	Armed Fo	e		Was Decedent of I f Yes, specify Cub I ☐ Yes 2 🋣 No	an, Mexica	an, Puerto R	ify Yes or No- ican, etc.)		Black, Wh	nerican Indian, hite, etc. hite	
5-00	hours natura dical E	lete	15. Deced	lent's Education			dent's Usual Occu			. 1	16b. Kind	d of Busines		
21215-0036	hin 72 ne. <b>than "</b> te Mec	Completed	Elementary/Seconday (0-12)	hest grade completed) College (1 5+			kind of work done O NOT use retired	)	ost of working	9		Otan	Home	
	filed wit al Hygie d other event, th	Be C	17. Father's Name (First, Middle				Homema	1	ther's Name	(First, Middle,	Maiden Su		TOME	
Maryland	should be file and Mental h 7 is marked o raumatic eve	욘	G	eorge C. P	affenba	rger				achel .			ın	
Man	should h and f 7 is ma rauma		19a. Informant's Name/Relation			1	ng Address (Street							
	and 2 s Health tem 27 i		Howard A.  20a. Method of Disposition	Minners/H	20b. F	Place of Dispo	sition (Name of	- 1					and 20814 or Town, State	
mo	Page 1 nent of int; If i		1 ☐ Burial 2 🛣 Crematio 4 ☐ Donation 5 ☐ Other		State	emetery cren Montgo Cremat	matory or other pla mery orium, I	nc.	November 201		Beth	esda,	Maryland	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Licensee	M013	Ra	Bertani Adm 57 Wiscons	emolfice	y Funer	ral Home	Bethe:	sda-Che	evy Chase, Inc	c.
			23a. Part 1. Enter the disease, shock, or heart failure. Lis-	or complications that of	caused the deat ich line.	h. Do not ente	er the mode of dyi	ng, such a	s cardiac or	respiratory arr	est,		Approximate Interval Between	
	Physician/ Medical	ă î	Immediate Cause (Final disease or condition resulting in death)	a	·	CARCIN	OMA						Onset and Death	1
-	Examiner				uence or):									
	n #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	or as a consequ	uence of):								
18	ate be executed physician and the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):						_		
0	e be ey ysiciar e buria	edical		d										
68760	rtificati ing ph		IF FEMALE:						- <u>-</u> -					
Box 6	Attending Physician: The law requires that the death certificate be executed ar death.  **r death.**  **ector Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transity the funeral director.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live	nant at time of	al death 3	Ectopic pregnar Other (specify)	псу			23	3d. Date of Month	delivery Day Year	
P.O.	that the		Part II. Other significant condi	tions contributing to d	eath but not res	sulting in the u	ınderlying cause g	iven in Pa	rt 1.	23e. Did to	obacco use	e contribute	to the cause of death	?
of Vital Records,	requires the been signer should be a	Completed by								1 🗆 '	Yes 2 🗓	No 3□	Probably 4 Unki	nown
900	a law re has bu ye 2 sh	mple								24a. Was a autop		24b. Were prior death	autopsy findings availa to completion of cause ?	able e of
Ä	ician: The la certificate ha rector, page		25. Was case referred to medica	al I			26.5	Place of De	eath (Check	1 x Yes	2 🗌 No		Yes 2 🔀 No	
Vita	nysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 🛣No	Hospital:	Inpatient 2 🗆	ER/Outpatier	Ot	her		ne 5 🗆 Resid	dence 6	Other (Sp	ecify)	
of	ng Phys fter this ineral di		27. Manner of Death  1 😾 Natural 5 🗌 Pend	28a. Date		28b. Time of injury		ry at		8d. Describe h				
sion	ttendi death. xtor: A / the fu	Certificate:	2 Accident Inves	stigation d not be	of Injuny - At he	me farm str	M 1 C	Yes 2		19f Lonation /S	troot and	Numberor	Rural Route Number,	
Division	al or A s after il Direction by		4  Homicide deter		ng, etc. (Specify		eet, factory, office		2	City or Tow		vurnber or	nurai noute ivumbei,	
_	To the Hospital or Attending Physical Within 24 hours after death.  To the Funeral Director After this completed filled in by the funeral di	Medical	(Check 2 Medical	ng Physician: To the bases of Nurse Practioner:	sis of examination	n and/or inves	tigation, in my opir	ion, death	occurred at t	he time, date a	ind place, a	and due to tl	ne cause(s) and manner	stated
	To the within To the comp		29b. Signature and title of certifi		10 110 2001 01 111	y monoago, c	29c, Licen						nth, Day, Year)	
								12454	49 (VA	A)	10	28	11	
	20		30, Name and address of person						WRNMM		0000	0.500		
	Stat	e.	31. Date filed (Month, Day, Year)	62. B	Rockvi				RETHE	SDA MD	<u> </u>	9-360	U	
			NUA U S	71111 VW.	was B	. 14	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EXN BEL 10:20 PM Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner edéca Baltrune 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours 242-72-106 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director BATIMORE MD1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA ST MATTHEWS 21202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc 2 1 Never Married 2 Married ☐ Yes 2 🔀 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE CITY TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ JOHN MCLEAN WILLIE MAE KELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOLEAN item 27 i DAVGHTER REVERDY 1000 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

#☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or once. ò 11/4/2011 BALTIMORE, MD GARDEN OF FAITH 22. Name and Address of Facility VAUGHN GREENE FUNERAL SERV 21. Signature of Funeral Service License ORK ROAD. BALT IMORE, MD. 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer lu Bracrecuia Immediate Cause (Final Physician/ disease or condition resulting in death) day Medical Due to or as a consequence of: Examiner (etchrovexular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by teted filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Tes ER/Outpatient 3 DOA မ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 0 2 2011

301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2011 Maria Tama Maggio 11:51 AΜ Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Towson 300 E. Joppa Rd., Apt. 1306 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Ecuador Hours 214-38-2118 1 🗆 M 2 💢 F September 8,1921 90 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Maryland Baltimore Towson 1 ☐ Yes 2 🕅 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21286 300 E. Joppa Rd., Apt. 1306 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Spanish Specify: white "natural", 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) medical librarian health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carmen (unknown) Manuel Tama .. Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Maggio/son 13218 Wye Landing Lane Wye Mills, MD 21679 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Green Mount Crematory Nov. 1,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Service of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A. 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest block, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or linjury Examine the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical l & 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\text{Residence}}\) 6 \(\sum \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 2 Accident
3 Suicide
4 Homicide Investigation a er death Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. atore and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ October 28 2011 2300 M ROSE Medical MILLER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore City N/A Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Hours 1 🗆 M 2 🔀 F Director 220-38-5873 99 Yrs. 03/05/1912 MD 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 3713 BANCROFT ROAD 21215 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SAMUEL COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tran SHEILA BRISK/DAUGHTER 3713 BANCROFT ROAD, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2011 SHEARITH ISRAEL BALTIMORE, MD 21. Signature of Mineral Service-Licenser 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ set and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 Mo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 Yes Yes 25. Was case referred to medical examiner?

1 \sum Yes 2 \infty No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred A Hospins.

24 hours after death.

ne Funeral Director: Aft Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completely i (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier October 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 45-10 R1241 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar 34892 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 3. Time of Death 8:47<sub>a M</sub> 2. Date of Death Physician/ det. 2011 Wanda L. O'Katch Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3529 Honeysuckle Lane Middle River If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Director 215-20-6275 1 M 2 X March 28, 1928 83 Yrs MD Usual Residence of Decedent 28a-f shov aţ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified MD Baltimore Middle River 1 Yes 2 XNo 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? **23**a Funeral 3529 Honeysuckle Lane 21220 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ★o Specify. "natural", 3 XWidowed 4 Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Seamtress and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ဂ Hobert Carr Daisy Showalter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Feltner /granddaughter 3529 Honeysuckle Lane Balto. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation Bayview Crematory 10/31/11 5 Other (Specify) Baltimore MD 22. Name and Address of Facility 300 MAce Ave, Balto. MD 21. Signature Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, specifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andiovascula iseaso sclero Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 Pregnant at time of death No Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 10 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work' 1 🗌 Yes 2 🗌 No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 29d. Date signed (Month, Day, Year) 1866 30. Name and address of person who completed cause of death Item 23a) (Type, Print) GTRIMBLEHILL CT. LUTHER VILLE MDZ1093 LLO PHILIP MILITE MID 31. Date filed (Month, Day, Year) 32. Registrar's Sign State

DHMH 17 Rev 06-2011

Registrar

NOV 0 2 2011

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10/26/2011

WANDA O'KATCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arl Powell		State of Maryland / Department of 1-For State Registrar Certificate of		giene Reg. No. 201	34893				
Physic Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year October 28, 2011	3. Time of Death 0717 hrs				
			b. City, Town, or Location of Death Baltimore	4c. County of Death $N/A$	n e				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $212 - 44 - 5280 \qquad 1 \text{ IM} \qquad 2 \text{ F} \qquad 65 \qquad \text{Yrs.}$	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Bir					
w any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits				
Maryland 28a-f show	Director	Md. Baltimore City Baltim  10e. Street and Number	Ore 10f. Zip Code	10g. Citizen of What Cou					
5 72 hours after death with the Maryland 1 "natural", or items 23a or 28a-f sho 1-al Examiner must be notified at once	न्त्र		21216  Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto F		ican Indian, Black,				
iter de	by Fune	3 Widowed 4 Divorced If Yes, Glve Yeer or Dates:	Yes 2 No specify:	Specify: Bla					
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during mo	's Usual Occupation (Give kind of west of working life. DO NOT use retire	ed)	,				
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle, Last)  Robert Powell	Technician  18.Mother's Name  Annie	<u>  UMM Syste</u> (First, Middle, Maiden Surname)   Sherrod	em				
MD 212 d 2 should be lth and Ment a 27 is mark	To E	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing	Address (Street and Number or Re	ural Route Number, City or Town, State e, Baltimore, Mo					
	) (8 ) 19	20a. Method of Disposition  20b. Place of Disposition  Removal from State  20b. Place of Disposition or oth	tion (Name of cemetery, er place)	Date 20c. Location - City or	Town, State				
Baltimore, permit. Pages I ar Department of Hee Important: If ite	. S			4/2011 Baltimor Funeral Service e, BAltimore, N					
Physician		23a Part I Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death				
Examiner		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  b.	Jacobial Dioduce						
٣ ـ =	Examiner	if any, heafing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):							
0, e be executed sician and burial - transit	edical E	d.  UNPENDED X AMENDED 27,28a-f per m	ne g924 2-2-12 <b>v</b> t						
OX 6876 ath certificate attending phy or use as the l	Physician/Me	past 12 months?	al death 3 Ectopic pregnar er (Specify)	23d. Date of deliver	y Day Year				
i, P.O. Baires that the designed by the	by	Part II. Other significant conditions contributing to death but not resulting in the un Blunt Force Head Trauma; Chronic Obstructive Pulmonary D		23e. Did tobacco use contribute to					
Division of Vital Records, tal or Attending Physician: The law require as a fairer dealh.  In Director: After this certificate has been sited in by the funeral director, page 2 should b	ompleted			autopsy prior to c performed? death?	utopsy findings available completion of cause of				
Vital Re ysicion: The his certificate director, page	o Be Co	25. Was case referred to medical 26. Place of Death (Check only one)  examiner?  [Hospital:   Insertion   2   FR/Output   2   DOA   Other   Number   Long   2   Place   2   Pl							
ion of \ itending Phy leath. tor: After th		27. Manner of Death  1 Natural  28a. Date of Injury (Month, Day, Year)  28b. Time of Ingury (Month, Day, Year)  1 X Accident Investigation  1 10 - 28 - 11	1 Yes 2 F No	28d. Describe how injury occurred subject fell					
Division spital or Attentours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined Specify found: 1ocal s	10	or Town, State)					
Divis  To the Hospital or A within 24 hours after To the Funeral Dire	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurr one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occurred at	the time, date and place, and due to the	e cause(s)				
	₹	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo October 29, 201					
8		30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 900 V	V. Baltimore Street, Baltim	ore, MD 21223					
S Regis	tate trar	31. Date filed (Month, Day, Year)  NOV 0 2, 2011  33 Registrar's Signature	W						

			Please Type amend # 6a 1 - State Registrar	or Pri	nt in Bla	ack In	idelible Inl	<b>c. Ensure A</b> /2011 JH Jealth and N	All Copie:	s Are	Legible.		
			1 - For AMI State Registrar	END' II	TEM#201	per Cer	FH,G921, tificate of L	(178/2011 Death	,WS	Reg. No.	2011	34894	
			Decedent's Name (First, Middle, Last)				<del></del>		2. Date of De	ath		3. Time of Death	
	Physicia Medio		Richard C. Parris				_		Octobe	er 31	, 20°11	9:16 A M	
	Examin	er	4a. Facility Name (if not institution, give street and 24 W. Mayer Dr.	d number)				c. City, Town, or Location of Death Finksburg  4c. County of Death Carroll					
	Funeral Director		5. Social Security Number 6. Sex 1X M 2 [	7. Ag	e (In yrs. last l 74	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCt • 1	th 1 Year) 1 , 1 9	9. Birth Cou.	nplace (State or Foreign ntry) Yland	
	d ow		Usual Residence of Decedent  10a, State  10b. County		10c. City, To			<u> </u>				10d. Inside City Limits	
	a-f sh	cto	MD Carroll			inks						1 Yes XX No	
	or 28 e noti	Dir	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?	
	s 23a	<b>Funeral Director</b>	24 W. Mayer Dr.				2	1048	Ĭ		U.S.	. A .	
336	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. ittem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	کے	1 Never Married XXMarried 1 If Ye	Decedent Fed Forces? Yes XXX s, Give or Dates.	Ever in U.S. No	- 1	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes ※XXNo	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: V		
2	hours matur dical	olete	15. Decedent's Education (Specify only highest grade comp		1	6a. Deced	lent's Usual Occupa	ation Juring most of work	ina	16b. Kin	d of Business Ir	ndustry	
Maryland 21215-0036	within 72 giene. er than ' , the Me	Completed		ege (1-4 or 5	5+)	life. DO	ONOT use retired)  OFOMAN	Scale Ma			ecyclin <del>emeter</del>		
b	tal Hyg d oth event	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam					
Z S	uld be d Men marke natic	۲	Emmett Parrish		k Wilse			Ione		rris			
Σ	2 shoth the shot		19a. Informant's Name/Relationship (Type, Print)  Valerie Caldwell / I					nd Number or Rura r Dr. F					
Baltimore,	of Hea of Hea fitem		20a. Method of Disposition		20b. Place	e of Dispos	sition (Name of	0)	Date	20c. Loc	ation - City or 7	Town, State	
Ĕ	Page 1 ment of l ant: If it		1 ☐ Burial 2XXCremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	All	Far	iths	11/2	/2011 2/11	Mano	cheste	r, MD	
alt	permit. Page Department of Important: If any injury or once,		21. Signature of Fine / I Service Licensee	/	2 (3)	22	. Name and Addres	s of FacilityECK	hardt	Fune	ral Ch	r, MD apel P.A.	
	TD = # 0	9 1	23a. Part 1. Enter the disease, or complications	that caused	_	TI	005 Ke1	SCELSCO	wii Ku.	OWIN	gsmii	1s, MD21117 Approximate	
	nysician/	81.2	shock, or heart failure. List only one cause Immediate Cause (Final	on each line	e.							Interval Between Onset and Death	
Medical resulting in death)  a. Due to (or as a consequence of):							1 mnedia He						
	Examiner	<u>.</u>	Sequentially fist conditions, b	OY0	nary	C	urtert	de	5629	'e			
N	ed sit	Examiner	Secusive list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	ue to (or as	a consequenc	ce of):							
48	xecute n and al-tran		that initiated events c	ue to (or as	a consequenc	ce of):							
	e be e iysicia ie buri	lical	d									_	
68760	rtificat ling ph e as th	/Mec	IF FEMALE:										
. Box (	I law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	Live Birth	of pregnancy 2  Fetal de t time of deat	eath 3	Ectopic pregnanc Other (specify)	у		2	3d. Date of deli	very Day Year	
P.O.	that the ned by a deta	by PI	Part II. Other significant conditions contributing						23e. Did t	obacco us	e contribute to	the cause of death?	
ds,	quires en sig ould by	ted	Diabetes	sien			/ ~	<u> </u>	1 🗆	Yes 2	No 3	obably 4 🗆 Unknown	
Division of Vital Records,	The ate pag	Completed	Diabetes	Me	llifu	ه کي	t the I	<u></u>	24a. Was auto perfo 1 \( \subseteq \text{Yes}	psy ormed?	prior to c death?	opsy findings available ompletion of cause of	
ā	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?				Othe	ace of Death (Check	k only one)				
Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death  28a. Date of injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred								<u>(v)</u>					
uc Ouc	inding ath. r: Afte ne fune	icat	2 Accident Investigation	(Month, Day	y, Year)	injury	work						
DIVISI	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	al Certificate:		Place of Inju ouilding, etc		, farm, stre	eet, factory, office		28f. Location (S City or Tov		Number or Rura	al Route Number,	
	ne Hosp in 24 hou ne Funer pleted fil	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To	e basis of e	xamination and	d/or invest	igation, in my opinic	n, death occurred at	the time, date a	and place, a	and due to the c	ause(s) and manner stated.	
	Vith To th	_	29b. Signature and title of certifier	M	0		29c. License	number 3 443		29d. Date	signed (Month,	, Day, Year)	
	9		29b. Signature and title of certifier  Control  30. Name and address of person who completed  AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	cause of d	eath (Item 23a	a) (Type, P	rint) (Limp)	e RIVE	l Wes	tmir	ster 1	MD 21157	
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 0 2 2011	32. Registra	ar's Signature	bare	V						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2<sup>Day</sup> 2 0°11 JOHN PRAITHER M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 2<sup>M</sup>975, P2, 3°3°5 NORTH CAROLINA 242-44-5063 **Director** 76 Yrs 1X M 2 F 28a-f show with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director WASHINGTON DC 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral UNITED STATES 2113 MARYLAND AVE NE #1 20002 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bace - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give þ permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinants once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ 9th PRIVATE LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNK UNK 19a. Informant's Name/Relationship (Type, Print) SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTONIO WHITE/GREAT GRAND-2113 MARYLAND AVE NE#1 WASH. DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREM. 1 Burial 2 Cremation 3 Removal from State 10/28/2011 4 Donation 5 Other (Specify) BELTSVILLE, MD 21. Sign Funeral Service CAPITOL MORTUARY 20002 1425 MARYLAND AVE NE WASH., r complications that caused the death. Donly one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Li not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition ARRHYTHMI Medical resulting in death) **Examiner** COLON CANCER Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Month Day Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autons death? certificate Yes 2 X No 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVERLY, MD20785 31. Date filed (Month, Day, Year, State Registrar DHMH 17 Rev 06-2011

Registrar	rtificate o	f Death		Reg. N	o. <u> </u>	348
				Date of Death     Month Day	/ Year	3. Time of Death
		4h City Tourn	or Location of Doc			1919 hrs
11336 Youngstoun Drive, Apt. 1809					Washington	atti
5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Under 24H	Irs. 8. Date of Birth (M		
111-38-6117 <sub>1 M 2XF</sub>	64 Yrs		ays Hours M			eign Country) A.L
					- · l	
						10d. Inside City Limit
	ersto			140.0		
11336 Youngstown				10g. C		
	e [42 \M/			Specify Von or No		
1 Never Married 2 Married Armed Forces?					White, etc.	erican indian, black,
3 Widowed 4 X Divorced If Yes, Give Yeer	1	Yes 2X	lo s <i>pecify:</i>		Specify: B1	ack
15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usual Occup	pation (Give kind o			
Elementary/Secondary (0-12) College (1-4 or 5+)		•				
12th 2 yrs.	Real	Estate				tate
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<del>-</del>	-	7-0-1-				
Tinarsha Tanarsha Brown-Daughter	1					
2						
A Durial 2 Oremation 3 Tremoval non state			111			
4 Donation 5 Other Specify.			•			
Signature of Puneral Service Licensee	A v	ve . Ba.	ltimore	, MD 2120	)2	. NOLUII
23a. Part I. Enter the disease, or complications that caused the death	Do not enter t	he mode of dyin	g, such as cardiad	or respiratory arrest, s	hock, or heart	Approximate Inter
failure. List only one cause on each line.	ma.					Between Onset ar Death
### ### ### ### ### ### ### ### ### ##						<del>-</del>
Sequentially list conditions, b						
fany, leading to immediate Due to (or as a consequence or	f):					
Disease or injury that initiated C.	f):				West Control	+
d. ,,	•					
UNPENDED #19a,	perFH,G	921,11/ 11/2/2	9/2011,W	S		
F FEMALE: 23c. If yes, outcome of pregi		, , , , , , ,	.011,115		3d. Date of delive	ery
past 12 months?		tal death 3	Ectopic preg	nancy	Month	Day Year
Von 2 M No 0 Ulpknoum	atn 5 Ot	her (Specify)				
	esulting in the u	underlying cause	given in Part I.	23e. Did tobaco	o use contribute t	o the cause of death?
Chronic Alcohol Abuse				1 Yes 2	No 3 Pr	obably 4 🗹 Unknow
				24a. Was an	24b. Were a	autopsy findings availal
				autopsy performed		completion of cause o
				1 <b>✓</b> Yes 2		Yes 2 No
examiner?	EDIO A t' - ·		Other -			
1 Yes 2 No						er: Scene
1 Notural - (Month, Day, Year)	FOUND:	1		Subject fell	gan y cocumeu	
2 Accident Investigation Oct 29, 2011	1900 hrs	et factory office		28f Location (Street	and Number or E	Rural Route Number, Ci
3 Suicide 6 Could not be 200. Place of Injury - Action		er, radioty, billion	Daniany, Old.	Low Freduction (20166)	GIRLINGI OF F	raidi irouto Nullibol, Ol
	Pinky Lee Roberson	Pinky Lee Roberson  4a. Facility Name (firot Institution, give street and number)  11336 Youngstoun Drive, Apt. 1809  5. Social Security Number  111 - 38 - 6117  11	Pinky Lee Roberson   As Facility Name (first, Middle, Last)   Pinky Lee Roberson   As Facility Name (find institution, give street and number)   As Facility Name (find institution, give street and number)   As Facility Name (find institution, give street and number)   As Facility Name (find institution, give street and number)   As Facility Name (find institution)   As	Pinky Lee Roberson  4a. Facility Name (if not institution, give street and number)  1.1336 Youngstoun Drive, Apt. 1809  5. Social Security Number  1.1336 Youngstoun Drive, Apt. 1809  5. Social Security Number  1.1336 Youngstoun Drive, Apt. 1809  7. Age (in yrs. last birthday)  1. Morital Status  1. Morital Status  1. Morital Status  1. Morital Status  1. Marital Status  1. Marital Status  1. Marital Status  1. Morital Status  1	Decedent's Name (Frist, Middle, Last)   Decedent Son	Disposition Name (First, Middle, Last)   Pink Y Lee RoberSon   2. Date of Debin Day October 29, 2011   Year Accounty Number   11336 Youngstoun Drive, Apt. 1809   7. Age (in yrs. last birthday)   4c. City, Town, or Location of Dash   4c. County of Design   4c. County of Des

Examiner

Physician /Medical

Division of Vital Records, P.O. Box 68760,

To the Bropital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Properal Diverse. To the Fuorara Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

29b. Signature and title of certifie

Russell Alexander MD

30. Name and address of person who completed cause of death (Item 23a)

Sequentially list conditions,	b.	
if any, leading to immediate	Due to (or as a consequence of):	
cause. Enter Underlying Cause	Due to (or as a consequence of):	
events resulting in death) Last	1. "	
UNPENDED	**************************************	
IF FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delivery
23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknow	1 Live birth 2 Fetal death 3 Ectopic pregna 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ncy Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Chronic Alcohol Abuse		1 Yes 2 No 3 Probably 4 V Unknown
		24a. Was an autopsy performed?  1 ✓ Yes 2 No 2 Yes 2 No
25. Was case referred to medical	26 Place of Death (Check of	only one)
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	g Home 5 Residence 6 🗹 Other: Scene
27. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Ponding		Subject fell

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

OGME

October 30, 2011

29d. Date signed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 1255 Horber Medical George
4a. Facility Name (if not institution, give street and number) Ratliff **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Greneral Hospital Baltimore Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Date of Birth Birthplace (State or Foreign Country) Date of bits. (Month, Day, ) Q 12 **1**X M 2 □ F Days Hours Min Director 217-54-1144 61 MD Usual Residence of Decedent ortant: If item 27 is marred other than "natural", or items 23a or 28a-f show injury or other traumatir event, the Nedical Exminer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21217 2324 Bryant Ave 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 12th grade Conrail Railroads Conductor Be permit. Page 1 and 2 should be filed verbartment of Health and Mental Hygements. If item 27 is man ed oth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Curtis George Ratliff Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7826 Fox Farm Lane, Glen Burnie, Md 21061 Lori Ratliff-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 11/7/2011 Woodlawn Woodlawn, Md Signature of Funeral Service License March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nodinte Cause (Final Onset and Death Physician/ Pymonary Were disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Dav the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy
performed?

1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla				Mental Hygi	iene	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	<i>Death</i>	2. Date of Death	eg. No. 20	3. Time of Death
П	Physicia Medic		Woodrow William Ra	ankin				October	27, 2011	5:00 P M
~~	Examir		4a. Facility Name (if not institution, give si	treet and number)		4b. City, Town, or	Location of Dea		4c. County of Death	
-	,	М	6307 East Halbert			Bethes			Montgon	
	Funeral Director		5. Social Security Number  104-05-9805  Usual Residence of Decedent	7. Age (In yrs	s. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 1918 New	nplace (State or Foreign Intry) York
	and show	į	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl 28a-f otified	Director	Maryland Montgome	ry Be	thesda					1 ☐ Yes 2 <b>黛</b> No
	th the 3a or t be n	<u>a</u>	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath w	Funeral	6307 East Halbert	Road  2. Was Decedent Ever in	IIS 13 V	20817 Vas Decedent of Hi	enanic Origin? (9		nited State	
920	s after de ral", or itu Examine	٥	1 ☐ Never Married 2 🏋 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	T. J. T. T.	f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f show er than "natural", the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	cation e completed) College (1-4 or 5+)	(Give F	lent's Usual Occupa kind of work done of NOT use retired)	ation luring most of wo	irking	16b. Kind of Business I	ndustry
121	iled within I Hygiene. other tha ent, the N	Be C	17. Father's Name (First, Middle, Last)	5+	Engine	eer			<u> Fransportat</u>	ion
lanc	- 00 T	일	John Rankin					me (First, Middle, M	,	
ary	of and 2 should be file of Health and Mental I fitem 27 is marked of rother traumatic eve		19a. Informant's Name/Relationship (Type	e, <i>Print</i> )	19b. Mailin	g Address (Street a		eth Fuller ural Route Number, (	: City or Town, State, Zip	Code)
Σ			Judith H. Rankin/W	ife	6307	East Hal	bert Ros	d, Bethes	da, Maryla	nd 20817
imore	Page 1 a nent of H ant: If ite ury or otl		20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	·-	sition (Name of natory or other plac on Cemete		mber $5, N$	20c.Location - City or ew Hampton ew Hampshi	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee  Houn M. Cho	B.	Rol	Name and Addres	s of Facility phrev Fun	eral Home. H	Bethesda-Chev Marvland 20	v Chase, Inc.
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	cations that caused the de						Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Adult Fai		Thrive				Onset and Death
Daver	Examiner		Toolaning in dealiny	Due to (or as a conse	equence of):					
		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					···
J.	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c	Dura to Assessment						
_	ate be executed physician and the burial-transi		resulting in death) Last	Due to (or as a conse	equence of):					
200	icate l	ledical	d							
Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of preg 1  Live Birth 2 Fe 4  Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnanc	у		23d. Date of delivery Month Day Year	
Ö.	hat the ed by detac	by Ph	Part II. Other significant conditions conf	ributing to death but not r	esulting in the ur	nderlying cause giv	en in Part I.	23e, Did toba	acco use contribute to	the cause of death?
ds,	quires en sigr uld be	ed b						1 🗆 Yes	s 2 <b>X</b> No 3 $\square$ Pro	obably 4 🗆 Unknown
Division of Vital Records, P.O.	he law rec te has bec age 2 sho	Completed			* North-ren			24a. Was an autopsy perform	prior to content?	opsy findings available ompletion of cause of
<u>=</u>	ian: T	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Che	1 \sum Yes 2 eck only one)	X Nol 1  Yes	2 No
Ξ	hysic this ce	ပ္	1 ☐ Yes 2 💢 No	ospital: 1  Inpatient 2 [		t 3 DOA Othe	r: 4  Nursing I	Home 5 X Resider	nce _6 🗌 Other (Specia	ý)
on of	ending Feath.	Certificate:	27. Manner of Death  1	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗆	at ? Yes 2 🗌 No	28d. Describe how	v injury occurred	
Divis	ital or Att irs after d al Direct led in by		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	ify)			City or Town,		·
	the Hosp nin 24 hou the Funer npleted fil	Medical	(Check 2   Medical Examine only one) 3   Certifying Nurse	ian: To the best of my kno r: On the basis of examinat Practioner: To the best of	ion and/or investi	gation, in my opinio	n, death occurred	at the time, date and	place, and due to the ca	ause(s) and manner stated.
	5 vit		29b. Signature and title of certifier	140.		29c. License		29	d. Date signed (Month,	Day, Year)
	atl		30. Name and address of person who con	- Juay	23c) /5 5	MD150	)1	0	ctober 28,	2011
	2		Michael Grady, M.D	4201 Cath	edral A	venue. Nu	J #114W	Washingt	on. D.C. 20	0016
	Stat	_	31. Date filed (Month, Day, Year) NOV 0 2 2011	32. Registrar's Sig	ature Saux	W	· naa-TWg	"don't ligt	on, D.O. Z	
	Registra	r	NOV U & ZUII	CHAMP P	19	-316				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 30 per dvr g921 11-2-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2 8 . 2 car HERMAN D RAYNES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) COURTLAND GARDENS BALTIMORE PIKESVILLE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**⊠**M 2□ F GA 255-30-2384 84 02/22/1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 GRISTMILL COURT, #303 21208 USA Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER ENGINEERING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY RAYNES 2 ROSE JACOBS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANITA RAYNES/WIFE GRISTMILL COURT, #303, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON CEMETERY
CHIZUK AMUNO CONG. 10/31/2011 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD\_21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 6 mon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ma 2 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? De la company Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 27. Manner of D≠ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner as the burial-transi attending physician for use as the buria Box 68760 signed by the a P.O. Division or Vital Records, certificate has birector, page 2 s or Attending Physician; director, After this funeral death.

કુ

Examiner Physician/Medical Completed by Be Certification: To Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

Baltimore, Maryland 21215-0036

To the Funeral Director: completely filled in by the I hours after within 24

2 Accident	investigation		M	1 ☐ Yes	2 □ No	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, street, facto	28f. Location (Street and Number or Rural Route Numb City or Town, State)		
29a. Certifier (Check only one)						e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

6 Could not be determined

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W. Belvedere Ave Baltimore, Md. 21215 Sunlip Rajani

State Registrar

31. Date filed (Month, Day, Year) NOV 0 2 2011

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 1207 AM Stacy OCTOBER 2011 Medical Ernest Stewart 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES FRANKEST Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**火** M 2 □ F Days Hours Months **Director** 216-36-5649 23 or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 X Yes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 2902 Ellicott Drive 21216 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Mail Handler <u>12th grade</u> na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file that and Mental H 27 is marked of raumatic ever မ Iola Shelton Ernest Stacy Stewart Sr. t. Page 1 and 2 should be dment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacie Stewart Daughter permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t John Street Halifax, NC 27839 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vetl1/4/2011 Owings Mills, Donation 5 Other (Specify) . Si matur of Funeral Service License 22. Name and Address of Facility 4366 Wabash Ave, BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ HEMORRHAGIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner BLEEDIN UNKNOWN JASTRO INTESTINA Sequentially list conditions if cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a nunhiquinnin of **the Hospital or Attending Physician:** The law requires that the death certificate be executed hin 24 hours after death. attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth
Pregnant
Unknown in the past 12 months? Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed HYPERTENSIEN 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 70718 OCTOBER 30 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CEDRIC DARK MD 21229 BALTIMORE AYENVE CATON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

## 11-07962 Tracy Shepherd

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rracy onephe		1- For State Registrar	or Maryland / Departr Certifi	icate of Death	iu Meritai r		eg. No. 2. ()	11 0100			
Physi Medical Exa		1. Decedent's Name (First, Middle,Last)				2. Date of Deat Month October 2:	th Year	3. Time of Death 0525 hrs			
		4a. Facility Name (if not institution, give	•		r Location of Dea		4c. County of Dea	ath			
Funera	ai	5. Social Security Number 6. Sex		Baltimore  irthday) If Under 1 Ye	ar If Under 24H	rs, 8. Date of Bird	th (MM/DD/YYYY) 9. E	Birthplace (State or			
Directo		216-68-7834	м 2 <b>Д</b> ғ 41	Yrs. Months Da	ys Hours Mi	<sup>n.</sup> 09/24	/1970 For	eign Country) MD			
áu.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location		-		10d. Inside City Limits			
/land	to like	MD	Bal	timore				1 X Yes 2 No			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. ten 27 in marked other than "natural", or item 23a or 28s-fabrements are to Maryland	eral Director	10e. Street and Number 6578 Saint Hele	na Ave Apt	10f. Zip Code 2	1222	10	ng. Citizen of What Co USA	ountry?			
th with	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba			0- 14. Race - American Indian, Black, White, etc.				
ifter dea	by Fu	3 Widowed 4 Divorced	1 Yes 2 No f Yes, Give Year or Dates:	1  Yes 2  N		. ,	Specify: W]	nite			
hours a	<b>3</b>   7	15. Decedent's Education (Specify only	y highest grade completed) 16a	a. Decedent's Usual Occupa during most of working life			16b. Kind of Busines	s/Industry			
036 rithin 72 me. r than '	Completed	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)	Graphic P	ainter		Bodysh	qo			
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. I then 27 is anxieted other than injury or other frammatic sense.	Be Co	17. Father's Name (First, Middle, Last) Donald Shower				e (First, Middle, M e Show					
212 hould b	To E	19a. Informant's Name/Relationship (Typ Michael Shepher	e, Print) 1	9b. Mailing Address (Stre							
and 2 sho lealth and tem 27 is		20a. Method of Disposition	20b. Place	513 Marlbo of Disposition (Name of ce		Lothi Date	an MD 20'				
MOTO Pages 1 ent of 1		1 Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State Atla	atory or other place) Intic Crem	10,	28/11	Glen Bu	rnie MD			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Sure sture of Funeral Service License	mplici	ty Crem &	R Fun Serv						
Physicia	n	23a. Part I. Enter the disease, or complice failure. List only one cause on each	cations that caused the death. Do i					Approximate Interval			
/Medica Examine		Immediate Cause (Final disease a. ]	Morphine, Oxycod	done, and Pho	entermin	e Intoxi	cation	Between Onset and Death			
	l.	Sequentially list conditions, b	ue to (or as a consequence of):								
	miner	if any, leading to immediate Due to (or as a consequence of):  Lause. Enter Underlying Cause (Disease or injury that initiated c.									
uted nd ransit		events resulting in death) Last Do	ue to (or as a consequence of):								
3760, ificate be executed g physician and s the burial - transit	Medical		AMENDED 23a,27,28		921 11-3	-11 vt					
58760 rtificate ling phy	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		y 2 Fetal death 3	Ectopic pregn	ancy	23d. Date of delive Month	ry Day Year			
Box 687 e death certific the attending ped for use as f	Physici	1 Yes 2 No 9 V Unknown	Pregnant at time of death Unknown	5 Other (Specify)			1	- 1			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fundantal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial - trans	by Ph	Part II. Other significant conditions	ontributing to death but not resulting	ng in the underlying cause	given in Part I.		pacco use contribute t				
'ds, Frequires						24a. Was a		obably 4 Unknown autopsy findings available			
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Sion Attendia death. ctor: A	atio	1 Natural 5 Pending 2 Accident Investigation	fd 10-23-11 fd	J. I dam	Yes 2 X No	subject	ingested	drugs			
Division or At ours after defend Direct filled in by	Certification:	3 X Suicide 6 Could not be determined	28e. Place of Injury - At home, f		ouilding, etc.	28f. Location (Si or Town, St Apt. C	treet and Number or R ate) 6578 Sat Baltimore	ural Route Number, City int Helena Av , Md.			
DIVIS  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in be		29a. Certifier 1 Certifying Physician	: To the best of my knowledge, de	eath occurred at the time, d		d due to the cause	e(s) and manner as sta	ited.			
To the vithing To the Comp	Medical	29b. Signature and title of certifier	nd manner stated.	29c. Licens		et the time, date a	29d. Date signed (M				
		" 1/1/		O.C.	M.E.		October 23, 201	1			
OCME		30. Name end address of person who con Mary G. Ripple MD. Depu	mpleted cause of death (Item 23a) ity Chief Medical Examine		Street, Balti	more. MD 212	223	···			
Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	a del	,	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year Martha B. Silliere @ 20 p M 10 30 /Medical 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | ROS ECIQ | E | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 21, 1921 SQUESTE FRANKLIN HOSPITal Baltimore 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Months Yrs. 376-24-4198 90 Director Michigan Usual Residence of Decedent 10a, State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f sho The Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8810 Walther Boulevard, #1126 21334 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Ye's or No-If Ye's, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2XNo þ If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene.
27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Raymond H. Berry Eska Eckles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. 27 Suzanne S. Barry/Daughter 17244 Sandy Knoll Drive, Olney, Maryland 20832 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State November 7, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 2011 Mt. Pleasant, NY 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 Home/ M00803 Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Septic 28 hours disease or condition resulting in death) Shock /Medical Due o (or as a consequence of): Examiner Tract infection urinary 28 hours Sequentially list conditions, if any leading Limited decays. Enter Underlying Cause (Disease or injury that initiated events Examine Dire to fur as a consecuence of attending physician and for use as the burial-transit obstruction 28 hours Small bowel P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical Acute 28 hours renal IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ፩ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed or Attending Physician: The certificate ! 1 □ Yes 2 ☑ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After th funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation I hours after death.

"uneral Director; Aftely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Yuling Zhanq WD D70605 October 30,2011

20

Marth

State Registrar

DHMH 17 Rev 1/2001

Yuling

31. Date filed (Month, Day, Year)

9000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN Square DR Balto md 21237

Lawrence . D. Sasubin, MD 8 Knowns Patient Division of Vital Records, P.O. Box 68760

		Please Type or Pramend item 5 r	int in l	Black I	ndelible In	k. Ens	ure A	II Copie	s Are	Legib	le.	
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Medi Examir	cal	LAWRENCE D. SARUBIN  4a. Facility Name (if not institution, give street and number)			4b. City, Town, o	r Location o		OCTOBE		. County of D	011 03: 19AM	
ZAGIIII												
Funeral Director		5. Serial Security Number 6 212-26-7038  Usual Residence of Decedent	ge (In yrs. la 83	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bit 10/03	rth 7 1928	g.	Birthplace (State or Foreign Country) MD	
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Page 1 ment of ant: If it ury or or		1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	~ <b> </b>		natory`or other plac HEBREW	· .		/2011		•	TOWN, MD	
permit. Page 1 and Department of Hea Important: If item any injury or other	j	21. Signature of Funeral Service Licensee		22	. Name and Addres	ss of Facility	SOL	LEVIN	SON 8	BROS	; INC ; MD 21208	
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the Hospit nin 24 hour he Funers npletely fills	Medical	29a. Certifier   1	examination	and/or investi	gation, in my opinio	n, death occ	curred at t	he time, date a	nd place.	and due to the	ne cause(s) and manner stated	
To t with To t		29b. Signature and title of certifier  RJMeWa			29c. License	number			29d. Date	e signed (Mo	nth, Day, Year)	
101		30. Name and address of person who completed cause of d			rint)		n .	1			21,2011	
State	Ÿ	RUTIKA MEHTA, MD, 31. Date filed (Month, Day, Year) 32. Registr.	-	re backs		Ur	IDA	LIMO	K &			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER EDWIN J SNYDER 2011 5:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min Director 219-18-7920 1 X M 2 □ F 89 08/02/1922 MD Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 ▼ Yes 2 □ No MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 3801 CANTERBURY ROAD, #714 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 K Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than, MECHANICAL Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. MECHANICAL CONTRACTOR CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ HYMAN SNYDER IDA PASS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is of Health air SHIRLEY SNYDER/WIFE 3801 CANTERBURY ROAD, #714, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specifi BALTIMORE HEBREW CEM 11/1/2011 REISTERSTOWN, MD 21. So at the of Euneral Sec. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. any 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Ph\_sician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ jo in the past 12 months? Day Year Pregnant at time of death signed by the ar Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital Other: 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA this 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only of 29b. Signa of certi D0071187 10-31-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Shaheeu, 6701N. Choules St. Swite 4105, Balthwell, MD 21204 20V

Registrar

DHMH 17 Rev 06-2011

Month, Day, Year)

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #22 Par FH 6921 of 1/02/2011 JHHealth and Mental Hydiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a&c Per FH G921 11/03/2011 JH State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tate 30 2011 9:15 PM Ronald october Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Windsor Mill Northwest Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Social Security Number 71 Months Hours **Director** 1 🕱 M 2 🗆 F Yrs Maryland 02/12/1936 75 28a-f show 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Directo Pikesville 1 Yes 2X No MD Baltimore Co. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21208 539 Woodside Rd. · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72. It and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Food Arama 8th Grade Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Connor Earl Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4303 Kathland Ave., Baltimore, MD 21207 Earlean Hairston(sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State Owings Mills, MD 11/04/11 4 Donation 5 Other (Specify) Garrison Forest 21. Signature of Funeral Service Licensee Joseph Trown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, tuchi rans MĎ 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final End-Stage Renal Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 3 Probably 4 Unknown 1 Yes 2 **V** No Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No death? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours aff the Funeral Di mpletely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2
To the f only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ns Rajapalnem'D DOUS7465 10/31/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 N.S. Rajapakk, M.D 2835 5203 Smith AV 31. Date filed (Month, Day, Year) 32. Registrar's Sig State parket NOV 0 2 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Roseabelle Thomas 2011 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchirst Hospice . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Min (Month, Day, Year) 212-26-4923 Director 1 □ M 2 🗶 F 97 Yrs 05 08 14 SC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Pikesville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 U.S.A. 1 Sutherland Ct. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc ō by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. "natural" 3X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 I (Give kind of work done during most of working al Hygiene. Raleigh life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Manufacturing Co. llth grade na Seamstress Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. Dora Cooke John Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sutherland Ct., Pikesville, Md 21208 Betty Griffin-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/7/2011 Memorial Arbutus, Md Arbutus of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lebili Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Or injury that initiated events Due to (or as a consequence of) executed the burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Day Year signed by the at Id be detached for Pregnant at time of death 2 No. Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performa certificate 1 Yes 2 No Yes director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' after death. 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. address of person who completed cause of death (Item 23a)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Terebetsky Sr. 2011 3:40pM Oct 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Ivy Hall Nursing Center Middle River Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth 169-14-2091 July 23, 1921 1 X M 2 □ F 90 PA 10c. City, Town or Location 10d. Inside City Limits Harford Fallston 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21047 1307 Erica Court USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Specify: White 1 ☐ Yes 2 ☑ No Specify. 3

Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, Trucking Company Elementary/Secondary (0-12) College (1-4 or 5+) Manager 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alex Terebetsky Kruchek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 Erica Court Fallston MD 21047 John Terebetsky /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery 10/31/11 Baltimore MD 21. Signature 22. Name and Address of Facility Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/ Medical Examiner

the attending physician and the for use as the burial-trans

signed by 1 pe

this certificate has page

within 24 hours after death.

To the Funeral Director: After completely filled in by the funer

Hospital or Attending Physician:

requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Physician/

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

Medical

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MD

Examine Be Completed by Physician/Medical IF FEMALE ျှ Medical Certificate:

29b. Signature and

title of certifie

ebostion

23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1		23d. Date o	•
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death?
			autopsy prior performed? performed?	e autopsy findings available r to completion of cause of th? Yes 2  No
25. Was case referred to medical		26. Place of Death (Check	only one)	
examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ [	DOA Other: 4 Nursing Hor	ne 5 Residence 6 Other (S	Specify)
27. Manner of Death  1 Z Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury M	28c. Injury at work? 1  Yes 2  No	8d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	8f. Location (Street and Number of City or Town, State)	r Rural Route Number,	
(Check 2 Medical Examir	sician: To the best of my knowledge, death occurred ner: On the basis of examination and/or investigation, in se Practitioner: To the best of my knowledge, death oc	n my opinion, death occurred at	he time, date and place, and due to	the cause(s) and manner state

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

M.D address of person who completed cause of death (Item 23a) (Type, Print)

30 D

1)0055171

29c. License number

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 27 2011 ax /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Himor e Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 M 2 KF 215-03-23/2 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Jry or other traumatic event, the Medical Examiner must be notified at Yes 2 No Director mor 10g. Citizen of What Country? 10e. Street and Number 2121 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Type. Print) Zitre xanjnex 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date VI Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Allantown, 4 Donation 5 Other (Specify)
21. Signature Funeral ervice Licensee Creenwood 22. Name and Address of F 1232 23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Due to (or as a confiquence of): hysician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Imami burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending properties of the pr 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Honknown Be Completed Point 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Diseane 24a. Was an was an autopsy performed? 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 University Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EVTAW ST SUIK 308, BALTIMORE MI) 212-1 ASHMI MD 32. Paintrar's Signature 31. Date filed (Month, Day, Year) State NOV O Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Donald A. Witt Sr. 8:25a M 31 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 221 Virginia Avenue Essex If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min 191-28-2857 Director 75 1 🖵 M 2 🗆 F Oct.10,1936 Yrs PA 10d. Inside City Limits 28a-f shov 10a, State 10b. Count 10c. City. Town or Location must be notified at Director MD Baltimore Essex 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a Funeral 221 Virginia Avenue 21221 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. o þ 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ xo Specify: Specify: White "natural". 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Armco Steel Mechanic 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of 2 George A. Witt Margaret Wadsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar. Important: If item 27 is any injury or are. Alexandra J. Witt /wife 221 Virginia Ave. Balto. MD 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State st. Joseph Cemetery Fullerton 11/4/11 MD Donatten 5 Dother (Specify) unera Service lic see 22. Name and Address of Facility 21. Signatur 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex Amplications that caysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, liy one cause on each line. 23a. Part . Enter the disease, or be shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ month disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) resulting in death) Last physician the buria Physician/Medical Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No lo Pregnant at time of death ed by the a detached t 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. n signed by t Ild be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 Yes 2 No 1 Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred iniury 5  $\square$  Pending Accident s after death.

I Director: Aff
ed in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge 29d. Date signed (Month, Day, Year) 29b. Signature ar title of certifier 29c. License number 3 0 completed cause of death, (Item State Registrar

DHMH 17 Rev 06-2011

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of de

NOV 0 2 2011

(Item 23a) (Type, Print)

2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

28

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

21224

Approximate

Interval Between Onset and Death

Yes 2 No

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White

8:00A M

DHMH 17 Rev 7/2009

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Reg. No. 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:40A WINSTEAD October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore None Keswick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2XX Months Days Hours 05/31/1934 **Director** 214-44-5881 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1**XX**Yes 2 □ No Maryland None Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 4631 Keswick Road USA 21210 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 200 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 X o Specify: Completed 3 Widowed 4 Divorced Specify: White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) Receptionist Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Hobson Woody Sarah Anne Mellier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Frances Helfrich 1 St Johns Road Baltimore, Maryland 21210 Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or oth cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) GreenMount Crematory 11/2/11 Baltimore, Maryland signature of Funeral 22. Name and Address of FM tchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie cause on each line. 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nursa Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 BALTIMORE N. EUTAW CUITE 301 SHARIM

DHMH 17 Rev 7/2009

State Registrar 32. Registra s Signature

11-07880	
Kevin Wright	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kevin Wright	1- For State	tate of Maryland /	Department of Certificate of		Mental I		2 0	11 31.01
Physician		lle,Last)		-		2. Date of Dear		3. Time of Death
Medical Examine	VEATIN	THOMAS	WRIGI			Month October 2	Day Year 0, 2011	0410 hrs
	4a. Facility Name (if not institution Washington Adventis	·		4b. City, Town, or Lo Takoma Park		th	4c. County of I	
Funeral	5. Social Security Number		(In yrs. last birthday)	If Under 1 Year	If Under 24H	rs. 8 Date of Bir		). Birthplace (State or
Director	220-27-5055	11 M 2 F	2.2 Yrs	Months Days	Hours M		lF.	oreign Country) Md.
	Usual Residence of Decedent	A	22 113			Aug	1909	lyICI .
w any	10a. State 10b. County	10	Oc. City, Town or Locat	ion				10d. Inside City Limits
-f shw	Md. Prin	ce George's	1	3rentwoo	od			1 Yes 2 No
the Maryland a nr 28a-f sh iffied at one Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	•
ith th		M Road.	or in H.S. I 42 M/s		722			States
or items 23 must be no	1 Never Married 2 M	arried Armed Forces?	If Y	s Decedent of Hispa es, specify Cuban, N	anic Origin? ( : Mexican, Puer	Specify Yes or No- o Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc.
s after d		orced If Yes, Give Year or Dates:		Yes 2 No	specify:		Specify:	Black
nours and	15. Decedent's Education (Spe	cify only highest grade compl	eted) 16a. Deceden	t's Usual Occupation	n (Give kind of	work done	16b. Kind of Busin	
36 in 72 i	Elementary/Secondary (0-12)	College (1-4 or 5+)	during me		O NOT use re	tirea)		
5-0036 led within 72 hour lygiene. wither than "natu the Medical Exan Completed	12th 17. Father's Name (First, Middle,	Last)		Clerk	Made and a bloom	e (First, Middle, M		vate
21215-0036 21215-0036 21 Amen Hygiene, marked uther than ic event, the Medica	Gilbert T.			10.		na Y. I		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked wither than "natural", or items 23a nr 28a-f show injury nr other transmatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relations	nip (Type, Print )	19b. Mailing	Address (Street a			ber, City or Town, S	tate, Zip Code)
MD and 2 shoulth and m 27 is a numerical	Verna Wrigh 20a. Method of Disposition	t / Mother	3710	Windom	Rd.		od, Md.	
Baltimore, permit. Pages I ar Department of Hee Impartant: If ite	20a. Method of Disposition  1 X Burial 2 Cremation		20b. Place of Disposi crematory or oth	tion (Name of cemet er place)	tery,	Date	20c. Location - Cit	y or Town, State
liment tant:	4 Ponation 5 Other Sp	ecify:	Ft. Line	coln Cem	ı. 10	-27-11	Brent	wood, Md.
Ball Permit Depart Impur injury	21 Signature of Funeral Service	Licensee 1.11	22. N	ame and Address of	Facility C	apito1	Mortuar	v
Physician	23a. Part I. Enter the disease, or	complications that caused the	Ateath. Do not enter th	25 Maryl	and A	ve NF	Wash.	DC 20002 Approximate Interval
/Medical	railure. List only one cause	on each line. /	/	,,,	or as variates	or respiratory are	or, shock, or flear	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Art Due to (or as a consequ	ence of): Cardio	mogaly w	ith Acr	mmotrio	Loft	Deati
<u> </u>	Sequentially list conditions,		<sup>ence of):</sup> Cardio Lar Hyperti	ophy	———	innectife	петс	
nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence.	ence of):					
ted Insit Examiner	events resulting in death) Last	Due to (or as a conseque	ence of):					
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760, cate be or physicia he buria	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of deli	verv
687 certifu nding se as t	23b. Was decedent pregnant in the past 12 months?	Live birth	o of do oth	al death 3	Ectopic is	ancy	Month	Day Year
). Box 6876( the death certificate by the attending phys ched for use as the b Physician/Me	1 Yes 2 No 9 Unki		or death 5 Oth	er (Specify)		***************************************	l.	
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Directur: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tedical Certification: To Be Completed by Physician/M	Part II. Other significant condition	ons contributing to death bu	t not resulting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Division of Vital Records, P.O. tat or Attending Physician: The law requires that it is after death.  Al Director: After this certificate has been signed by the funeral director, page 2 should be detactived in the funeral or See Completed by Priffication: To Be Completed by P.						1 Yes	2 No 3 F	robably 4 🗹 Unknown
Records, The law requires ficate has been sig page 2 should be						24a. Was ar		autopsy findings available to completion of cause of
Rec The la cate h page 2			-			perform 1 Ves 2	ned? death	?
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?	Hamital			Death (Check	, ,		
Physical direction	1 Yes 2 No 27. Manner of Death		2 ER/Outpatient		ier <sub>4</sub> Nursir		esidence 6 Ot	her:
n of ading Ph.  th.  After t e funeral	1 X Natural 5 Pendii	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj	ury 28c. Injury at		28d. Describe ho	w injury occurred	
isior Attend er death. rectur: by the	2 Accident Invest	igation	- At home, farm, street,			28f Location (Str	root and Number or	Divisió Deste Novelle de Ott
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 Could 4 Homicide determ	not be	, and an	raciory, office balla	irig, etc.	or Town, Sta		Rural Route Number, City
Hosp 24 hosp Runc Func stely fi	29a. Certifier 1 Certifying Phy	sician: To the best of my know	owledge, death occurre	d at the time, date a	and place, and	due to the cause(	s) and manner as s	ated
Division To the Hospital or Attend within 24 hours after death To the Funeral Directur; completely filled in by the	one) 2 Medical Exam	iner:On the basis of examina and manner stated.	tion and/or investigatio	n, in my opinion, dea	ath occurred a	t the time, date an	nd place, and due to	the cause(s)
ž	29b. Signature and title of certifier	1/000		29c. License nu		1:	29d. Date signed (#	Nonth, Day, Year)
	Carol	Hellav		O.C.M.E	E		October 20, 20	11
	30. Name and address of person was Carol Allan, MD Assi	tho completed cause of death stant Medical Examine		nore Street Pa	Itimore Mi	21222		
State		22. Registrar's Si				J 212 <b>23</b>		
Registrar	NOV 0 2 20		1. parle					

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Andre Jamal Wiggi	1- For State Registrar		aryland / De <sub>l</sub> C	partment of ertificate of		and Me	ntal Hy	_	Reg. No. 2 (		34915
Physician/ Medical Examiner	1. Decedent's Name (Fir ANDRE JAN	rst, Middle,Last) AAL WIGGI	NS					2. Date of Dea Month October 2	ath		3. Time of Death 1236 hrs
1 11		s Hospital Center			b. City, Town, Cheverly				4c. County of Prince G	eorge'	
Funeral Director	5. Social Security Number 5 7 9 - 2 5 - 7 0 5	7 X M 2		s. last birthday)	If Under 1 Y	ear If Un ays Hou	der 24Hrs. Irs Min.	8. Date of Bi 9 / 4 / 1	rth(MM/DD/YYYY 992	9. Birth Foreign Cour	WASHINGTO
yland •f show any Lonce.	Usual Residence of Dec 10a. State 10b. D.C.	edent County		ty, Town or Location	N						10d. Inside City Limits 1 X Yes 2 No
h the Maryland 23a or 23a-f sho rotified at once.	254 DIVIS	SION ST	NE		10f. Zip Code	)			Og. Citizen of Wh		
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 23a-f she imastic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		2 Married Arm 1 y Divorced If Yes, Giver Dates:		If Ye	Decedent of Hispanic Origin? (Specify Yes or Ns, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 X No specify:			Rican, etc.)	White	an Indian, Black,	
y, MD 21215-0036 and 2 should be filed within 72 hours feath and Mental Hygiene. trea 27 is marked other than "natur traumatic event, the Medical Exam To Be Completed t	15. Decedent's Educati Elementary/Secondary		et grade completed) ege (1-4 or 5+)	16a. Decedent	s Usual Occur st of working I	pation (Give ife. DO NO LABO	T use retire	ork done ed)	16b. Kind of Bus	siness/Ind	
21215-0036 ould be filed within 7 d Mental Hygiene.  Manker Hygiene.  Marker Hygiene.  Marker Hygiene.  Marker Hygiene.  Marker Hygiene.  To Be Comple	17. Father's Name (First,  DARYL TE 19a. Informant's Name/R			19b. Mailing	Address (Str	DON	NA	WIGGI	Maiden Surname)		(in Code)
re, P s 1 and f Healt If item	DONNA WIG	GINS/MOTH	IER 20b	254 D D. Place of Disposition Crematory or other	IVISI on (Name of or r place)	ON S	T NE	WASH Date	INGTON,	DC	20019
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other trees.	4 Donation 5 C 21 Signature of Funeral	Other Specify:	GL (1)	ENWOOD 22. Na 142	me and Addre	ss of Facili	ty Citt	TTOL 1	WASHI MORTUAR WASH.,	Y	ON, D.C.
Physician /Medical [xaminer	33a. Part I. Enter the die	e cause on each line. disease a. Multiple	Gunsbot Wou	th. Do not enter the unds	mode of dyin	g, such as	cardiac or	respiratory arro	est, shock, or hea		2 0 0 0 2 Approximate Interval Between Onset and Death
miner	Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that ini	ns, b ate Due to (or Cause tiated c.	as a consequence	of):							
E si e	events resulting in death;	dAMEND	as a consequence	of):							
O # € 5   ∑	IF FEMALE: 23b. Was decedent pregnate 12 months?  1 Yes 2 No 9	ant in the 1 L	yes, outcome of pre ive birth regnant at time of d	2 Fetal	death 3	Ectop	ic pregnan	су	23d. Date of d Month	lelivery Day	Year
i, P.O. E ires that the signed by the be detached d by Ph	Part II. Other significant	conditions contributi	ng to death but not	resulting in the und	lerlying cause	given in P	art I.		bacco use contrib		cause of death?
Division of Vital Records, tal or Attending Physician: The law requirer as after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed								24a. Was a autops perfor	sy pri m <u>ed</u> ? de		ssy findings available apletion of cause of
f Vital   Physician: r this certif ral director, To Be (	25. Was case referred to examiner?  1 ✓ Yes 2 □ 1	No Hospital: 1		ER/Outpatient	DOA	Other4			Residence 6	Other:	
sion of trending P death. ttor: After y the funera	27. Manner of Death  1 Natural 5  2 Accident	Pending Oct	Date of Injury Jonth, Day Yeer) 26, 2011	28b. Time of Inju 1154 hrs		ury at Work Yes 2 ✔	. ic	8d. Describe h ubject shot	ow injury occurred	d	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Anteoported filled in by the funeral price or property filled in Confidential Co	3 Suicide 6 4 Homicide 29a. Certifier	determined (Spec	Place of Injury - At r	et			52	or Town, St 219 Clay Stre	ate) eet North East, \	Washing	Route Number, City
To the Howithin 24 For the Run completely	(Check only one) 2 Medic	ying Physician: To the ai Examiner: On the ba and mann	isis of examination	dge, death occurred and/or investigation	ı, in my opinic	n, death oc	ace, and di curred at t	ue to the cause he time, date a	e(s) and manner a and place, and due	s stated. e to the c	ause(s)
	29b. Signature and title of		M			se number .M.E.			29d. Date signed October 27,	,	Day, Year)
	30. Name and address of Russell Alexande		cause of death (Iten nt Medical Exar	,	. Baltimore	Street,	Baltimo	re, MD 212	223		
State Registrar	31. Date filed (Month, Day	0.0044	Registrar's Signat	" park	1				-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct 0646 aon Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Talbot Memorial Easton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F (Month, Da 9 Months Hours Min **Director** Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Wes 2 No orchester 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. þ be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 To Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Anderson 19a. Informant's Name/Relationshi ype, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau ichard Pt. 201 Newport News Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State /2a/ 4 ☐ Donation 5 ☐ Other (Specify) 10 Grasonville, un Cemetery 22. Name and Address of Facility
Henry Funeral Home, A.A.
Henry Funeral Home, A.A. 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ Cosonary as tery disease or condition resulting in death) disease Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after deam.

To the Funeral Director: After this certificate has becompleted filled in by the funeral director, page 2 s autopsy performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 📝 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes ☐ Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signat are and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005325 P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Choptonk Butter 83 Preston Le lovida 31. Date filed (A State Registrar

Anderson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death aston Talbot . Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year Months Days Hours Min. Maryland Director Usual Residence of Decedent 23a or 28a-f show and Mental Hygiene.
'is marked other than "natural", or items 23a or 22...
'raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 No Yes 2 □ No a 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Son USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 I No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 10120/11 150 4 ☐ Donation 5 ☐ Other (Specify) Cemetery. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry Funtya Home, P.A. uneral MD, 21613 ington 23a. Part 1. Enter the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) CANOCA CCINOMA Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Box 68760 the attending pr IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has Le completed filled in by the funeral director, page 2 s. autopsy death? perforn Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 ☑ Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1/ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of pers on who completed cause of death (Item 23a) (Type, Print) Zugene 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Registrar

31. Date filed (Month, Day,

Box 68760

P.O.

of Vital

Division

32. Registrar's Signature

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	-	For State Registrar			State	OI IVIA	rylari	•		ate of L		anu	vieritai H	ygieri Reg. 1	0.0		31.0	310
Physicia	n/	1. Decedent's Name											2. Date of I	Death	bom C	- Vear	3. Time of	Death
Medic	al	HARRY T.  4a. Facility Name (if		,		mbori			I u o				OC YOUR	_			12:34	<b>P</b> M
Examin	er	209 GEN			reet and no	(TIDEI)			4b. City, Town, or Location of Death  BRYANS ROAD						4c. County of Death CHARLES			
Funeral Director		5. Social Security No. 214–46–6		6. Sex	М 2 □ F		(In yrs. la	ast birthday) Yrs.		der 1 Year	If Under Hours	-	8. Date of B			9. Birthr	place (State or	Foreign
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vith the Maryland 23a or 28a-f show st be notified at	Funeral Director	10e. Street and Nun 209 GENT		RT						Zip Code <b>2061</b>	6			10g. Citizen of What Country? UNITED STATES				
P P 9	اھ	11. Marital Status  1  Never Marri 3  Widowed			If Yes, G	orces? 2 No ive	er in U.S		If Yes, sp	ecify Cuba	ispanic Ori an, Mexicar Specify.	n, Puerto	ecify Yes or N Rican, etc.)	0-	Bla	ce - Americ ck, White, e	etc.	
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Phys er this c eral dir	و: :	1 ☐ Yes 2 27. Manner of Death	_	- 1	1 28a. Date	of injury		ER/Outpatier 28b. Time of		DOA Othe	4 ∐ NL	ursing Ho	ome 5 Res 28d. Describe					
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al or Att	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could r determi			of Injury ing, etc. (S		ne, farm, str	eet, facto	ory, office			28f. Location City or To			er or Rural	Route Numbe	r,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 v	Medical	(Check 2	Certifying Medical Ex	kaminei	r: On the ba	sis of exan	nination	and/or inves	tigation, i	n my opinio	n, death oc	ccurred a	t the time, date	and plac	e, and du	e to the cau	se(s) and mann	ner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOber Physician/ A. 15: 28 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death he Johns Hopkins HOSPITA Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕸 Days 999 99 9999 Months Hours Min. 0/1/10/1/2/01/1 Country MD Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f \$500 traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bryans Road MD Charles 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with ŪSA 20516 2700 Hammock Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🖾 No 1 Never Married 2 Married <u>Ş</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify:Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 ent of Health and Mental Hygiene. Tit if item 27 is marked other than "ny or other traumatic access." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname)
Tiffany Bond- Julian ಲ William Banks II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Bond-Julian Mother 2700 Hammock Ct. Bryans Rd., MD 20616 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Department Important: If any injury or Beltsville, MD Chesapeake Crem. 10/14/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signatore of Funeral Service Licens 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Extreme Prematurit disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 No ed by the a detached f Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by I 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No ြု 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatule and title of certi 29d. Date signed (Month, Day, Year) 29c, License number 10/10/2011 RES000 and address of person who completed cause of death (Item 23a) (Type, Print) street Baltimore Maryland

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32. Registrar's Signature

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State Registrar 31. Date filed (Month, Day,

Year)

Box 68760

**Division of Vital** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34922 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Stanley Physician/ Month; Bradshaw 951 2011 . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Howard Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Days Hours Och 16 1951 220-60-5803 59 Washington, DC **Director** Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Howard Ellicott City 1 Yes 2 □ No 10f. Zip Code 21043 10e. Street and Number 10g. Citizen of What Country? Funeral 2807 Union Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Engineer/Lineman Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doyle V. Bradshaw Audrey E. Beaver 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Nancy Lee Bradshaw -wife 2807 Union Drive Ellicott City, Maryland 21043 of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Durial 2 X Cremation 3 Removal from State 10/17/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee Bonald Wide Bofgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ myocardia disease or condition tare Medical resulting in death) Due to ( s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying an and Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No ed by the a detached t g Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? autopsy performed 2 HNO 1 Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A М Accident Investigation Suicide 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00066511 2011 oct 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rawat N ·Cedar Lane Columbia, MD Z1044 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:05 am Mary Berman October 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery Social Security Numbe . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Many Variable **Funeral** Days Months Director Yrs. New York 059-12-7526 09/11/1921 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Potomac 1 Yes 2 X No Maryland Montgomery 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral 20854 U.S.A. 11304 Crossing Glen Court 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced White Completed Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) New York City Gov't should be filed with and Mental Hygien 7 is marked other th 12 Child Social Services Worker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rebecca Schwartz permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Harry Berman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11304 Crossing Glen Court, Potomac, Maryland 20854 Kenneth Berman - Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Beth David Cemetery 10/18/2011 Elmont, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the discase shock, or heart failure. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest oly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ P.M.E disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Uisease or impury Examine Due to (or as a consequence of): burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or i that initiated events Due to (or as a consequence of): resulting in death) Last nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ or in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached for 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} 卢 2 No After this 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes hours after death, meral Director; Al 2 No upleted filled in by the Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, dea ath occurred at the time, date and place, and due to the cause(s) and manner as stated. \$5 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Date filed (Month, Day, Year)

OCT 18 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34924 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 13, 2011 Ε. Commerford Helen 11:45a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center E1kton Cecil If Under 1 Year If Under 24 Hrs,
Months Days Hours Min. Social Security Numbe 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Months Director 221-16-5956 Yrs 89 July 4,1922 Suderville.MD Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits PA Chester West Grove 1 Pyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Jenners Pond Road 19390 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white **3€**Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Clough Mamie McMullin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Shaw (daughter) 1633 Newark Road Kennett Square, PA 19348 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🗷 Removal from State 4 Donation 5 Other (Specify) Oxford Cemetery Oct. 19,201 Oxford, PA 22. Name and Address of Facility McCrery & Harra Funeral Homes & Crematory, Inc. 3924 Concord Pike Wilm 1989 21. Signator of Fun 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 4 mysiciam Onset and Death =eral disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events Pulm Hospital or Attending Physician: The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform 1 ☐ Yes 2 🗷 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: မ After this 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 🗌 Yes within 24 hours after deat

To the Funeral Director;
completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| 30c License number | 29d. Date\_signed (Month, Day, No. 1) | 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

Madhu Sachder, MD

2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

322 E. Cecil Avenue

32. Registrar's Signature

MD D0026183

Northeast, Maryland

29d. Date signed (Month, Day, Year)

10

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2011 10:12 PM Marjorie Frances Candore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prin<u>ce Georges</u> Patuxent River Health and Rehab Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 1 □ M **X**X F Year) 944 Months Days Hours Min Feb. Michigan 67 **Director** 376-40-6733 Usual Residence of Decedent , or items 23a or 28a-f shov miner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Tes 2 XXVo Maryland Prince Georges Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14200 Laurel Park Dr. #216 20707 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Laverne Edward Gordon Betty Romine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Whitehouse III(Son) 156 Konrad Morgan Way Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1)(X) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Donation 5 Other (Specify) Fort Lincoln Cemetery Oct. 21, 2011 Brentwood, MD MO1555 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ★ No
9 ☐ Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 🗆 No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my color 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ٩ to Shawan, MD 立的62534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA DTAWAN, MD 9055 Chevrolet Sr, Suite 103, EILI COTT CH

Registrar

Box 68760

Division of Vital Records, P.O.

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:47 P. M 2011 William т. October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 315 Ashton Road Ashton If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth 6. Sex Social Security Number Age (In vrs. last birthday) **Funeral** (Month, Day, Days Hours Country) 1 ₺ M 2 🗆 F Kentucky Director 87 June 402-20-7729 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No Maryland Montgomery Ashton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20861 315 Ashton Road United States and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1943 1 Never Married 2 Married X Yes 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes, Give "natural", 3 🛮 Widowed 4 🗆 Divorced 1945 White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical h and Mental Hygier 7 is marked other t 4 Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ent of Health and Menta it: If item 27 is marked y or other traumatic e Elizabeth Thelwood Crow Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashton Road, Ashton, Maryland 20861 Michelle A. Harde/Daughter altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/22/2011 Alexandria, Virginia Metropolitan Crem. re of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Completed by Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 Yes 2 Lg Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 No Yes 2 X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: 1 Yes Other: 2 🛛 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at work? 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

State

10+

David B. Harding, M.D., 18111 Prince Philip Drive, # 300, Olney, Maryland 20842

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

OCT 19 2011

D 35965

October 17, 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Print in Black I						
	-	1 - State of Maryland / Dep	ertificate of L		ental Hygiene Reg. N	2011	34928	
Physicia		1. Decedent's Name (First, Middle, Last)  Eleanor V. Cutrell			2. Date of Death  Month  October	8, 2011	3. Time of Death	
Medic Examin		4a. Facility Name (if not institution, give street and number) Abbey Manor Assisted Living	4b. City, Town, o	r Location of Death		c. County of Deat		
Funeral Director		5. Social Security Number  5. 77-24-4771  6. Sex  1		If Under 24 Hrs.	8. Date of Birth	g. Birt	hplace (State or Foreign untry)	
aryland a-f show fied at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Charles Marbur					10d. Inside City Limits 1 ☐ Yes 2 🟋No	
ith the Mi	ral Dir	10e. Street and Number 4615 Clymer Place	10f. Zip Code 20658	3	10g. C	10g. Citizen of What Country?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1  Yes 2  No  If Yes, Give	Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White		
nin 72 hours : he. <b>han "natura</b> e <b>Me</b> dical E;	Completed	Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  Ifa. Decedify in the complete of the complet	edent's Usual Occup e kind of work done o DO NOT use retired)	pation during most of working	g	Kind of Business	Industry	
ntal Hygien ntal Hygien ed other ti event, the	ادها	17. Father's Name (First, Middle, Last)  Lewis	cretary		(First, Middle, Maider		nment	
2 should b lith and Mer 27 is mark r traumatio		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street	and Number or Rural  7, Marbury	Route Number, City o	or Town, State, Zip	o Code)	
Page 1 and nent of Hea ant: If item iry or other		20a. Method of Disposition  1 W Burial 2 Cremation 3 Removal from State  20b. Place of Disposemetery, cre		oe) October	13, 2011 <sup>20c.</sup>	Location - City or	Town, State	
permit. Departr Imports any inju	1	21. Signature of Funeral Service Licenses	VILLIAMS I	ss of Facility uneral Ho norne Rd.,	me, P.A.		20640	
hysician/	,	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dyir	ng, such as cardiac or	respiratory arrest,	au, M.	Approximate Interval Between Onset and Death	
Medical Examiner	ı	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	7	7				
and I-transit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):						
×	edical E	d.						
r the attending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnand ☐ Other (specify) _	су	-	23d. Date of de Month	livery Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the CERE BROVASCULAR D(SEA	SE			use contribute to	the cause of death?	
ate has bee page 2 shou	Completed by	CARONIC ATRIAL FIBRILL	-ATION		24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of	
ysiciali: is certific director,	To Be (	25. Was case referred to medical examiner? 1	_ Oth	lace of Death (Check ler: 4  Nursing Hon	only one)	6 ☑ Other (Spec	Assisted	
to the Tropisal or Authorning Frinsical: The law, within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2.	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	worl	y at 2 k? Yes 2 No	8d. Describe how inju	ury occurred		
urs after d ral Direct	al Certi	4 Homicide determined 28e. Place of Injury - At nome, farm, st building, etc. (Specify)			28f. Location (Street a City or Town, Star	te)		
within 24 ho	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death only one)  3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opini , death occurred at th	on, death occurred at the time, date and place	the time, date and place, and due to the cause	ce, and due to the e(s) and manner as	cause(s) and manner stated. stated.	
o o o		29b. Signature and title of certifier	29c. Licens	2906	29d. L	Date signed (Mon	n, Day, Year)	
DC			Print)	DLINE C	wrek, W.	nover,	M 20602	
Stat Registra		31. Date filed (Month, Day, Year)  OCT 11 2011  32. Registrar's Signature	aska!					

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34929 State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ OCTOBER 6 2011 Year 2:10 P M VERNELL LORRAINE CRAWFORD Medical 4a: Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES 18405 BARNEY DRIVE ACCOKEEK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min NOV 2. 1952 NEW JERSEY Director 075-44-4326 58 Usual Residence of Decedent 3a or 28a-f show be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗶 Yes 2 🗌 No MD PRINCE GEORGES ACCOKEEK ms 23a or must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 18405 BARNEY DRIVE 20607 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 XMarried Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: Completed BLACK ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) DAY CARE PROVIDER CHILD CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be I Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e GLADYS GATSON CRAWFORD RUFUS CRAWFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18405 BARNEY DRIVE, ACCOKEEK, MARYLAND SEDGWICK CRAWFORD/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State OCTOBER 14, 2011 WALDORF, MARYLAND 4 Donation 5 Other (Specify) TRINITY MEMORIAL GARDENS Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON MOO583 INDIAN HEAD, MD 20640 3439 LIVINGSTON ROAD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line Interval Between RON CHOGSNIC ARCINOMA Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a sonsequence or). attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Medical Division of Vital Records, P.O. Box 68760 IF FEMALE Physician/ 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 No 1 Tes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 Residence 6  $\square$  Other (Specify) 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending Accident
Suicide Investigation 1 Yes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month Day, Year) 885 Name and address of person who pleted cause of death (Item 23a) (Type Print) margan 50 7

State

31. Date filed (Month) Day, Year)

32. Registrar's Signature

recon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene 2 U	1	

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	T State Registrar  1. Decedent's Name (First, Middle, Last)					Cer	rtificate of Death		Reg. No.			
Physician/ Medical FRANCI			FRANCIS CAGER	NCIS CAGER					2. Date of Deat Month 10/13/2	2011_	Year 5	3. Time of Death 5:32 A M
	Examin	4a. Facility Name (if not institution, give street and number)  204 Kendle Street					4b. City, Town, or Location of Death Upper Marlboro		4c. County of Deal		•	rge's
	Funeral Director		5. Social Security Number  217-34-1424  6. Sex 1   M 2 □ F  7. Age (In yrs. last bin 76			st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of		8. Date of Birth (Month, Day, 09/14/1	Birth 9. Birti		ce (State or Foreign
	how at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. Citv.	Town or Loc	cation				10d.	. Inside City Limits
	//arylar 8a-f si tified						Marlboro					1 X Yes 2 □ No
	h the la sa or 2 be no		10e. Street and Number			10f. Zip Code					What Country	?
	ath wil		204 Kendle Street  11. Marital Status   12. Was Decedent Ever in U.S			20774  6. 13. Was Decedent of Hispanic Origin? (Spe				USA 14 Bad	14. Race - American Indian,	
030	o filed within 72 hours after death with the Maryland Hygiene. I hygiene. I chter than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.			If Yes, specify Cuban, Mexican, Puerto Rican, e  1 ☐ Yes 2 ☒ No Specify:			Rican, etc.)	Black, White, etc.  Specify: Black		
<u>က</u> က	2 hours "natur dical					16a. Deced	Ga. Decedent's Usual Occupation (Give kind of work done during gost of working life. DO NOT use retired)  Photo Lit			16b. Kind of Business Industry		
7	thin 7% ene. • than he Me		Elementary/Seconday (0-12)		5+)			- Strippe		Federa l	l Gover	nment
Maryla	ild be filed wit Mental Hygie larked other i atic event, th		17. Father's Name (First, Middle, Last)  James Cager			18. Mother's Name (First, Fannie Will			e (First, Middle, N	ddle, Maiden Surname)		
	shou hand 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  204 Kendle Street, Upper Marlboro, MD 20774									
Baltimore,	ge 1 and 2 tof Healt or other								<u>_</u>	on - City or Town, State		
Ě	Par ant ury		4 ☐ Donation 5 ☐ Other	(Specify)		urrect	ion Cem.	10/19	<del>-</del>	Clintor		
e P	permit. Departi Import any inji		21. Signaturo Funeral Service	1 Ans	udi			ss of Facility Sno shington				)850
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that cause	ed the death.						Ap	pproximate iterval Between
-	h, sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Dementia			_ Oi	nset and Death Tuny y / S				
	Examiner		resulting in death)	Due to (or as	he; n	ence of):	Disea	rse_			17	7444 yrs.
	Α-	To Be Completed by Physicia	Sequentially list conditions, if any, leading to fininediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  b. Due to (or as a consequence of).  c. Due to (or as a consequence of):									
	ecutec											
20	ate be ex ohysician the buria											
BOX 68/60	the attending I		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	□ Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year				
,, O.	es that th signed by I be detac		Part II. Other significant conditions contributing to death but not resulting in the u				underlying cause given in Part I. 23e.			Did tobacco use contribute to the cause of death?  ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
ora ora	v requi		Coronary Artery Disease, Hy, Prostate Cancer				,		24a. Was an 24b. Were a		. Were autopsy	findings available
Vital Records,	The lav ate has bage 2								autops perforr 1 \(\sum \) Yes 2	med? 2 No	prior to complete death?	letion of cause of
<u>ra</u>	Within 24 hours are deading tripschair. The law requires that the board betallicate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-the statement of the completed filled in by the funeral director.		25. Was case referred to medical 26. Place of Death (Check only one)  examiner?  Hospital:									
O TO			27. Manner of Death  28a. Date of injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred									
00			1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No									
DIVISION			3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							oute Number,		
	he Hosp in 24 hou he Funei ipleted fil		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	## # ## B		29b. Signature and title of certifier				29c. License number			29d. Date signed (Month, Day, Year)		
30. Name and address of person wire completed cause of death (Item 23a) (Type, Print) 7500 6.  Stuart 7. Tur Fewitz, MD.  31. Date filed (Month, Day, Year) 32. Registrar's Signature of the sign							Greenv	array Cate. Dr. #430				
			Stuart T.	Turkewitz	, MD		Gree	nbelt,	MD Z	0770		
	Stat Registra	е	31. Date filed (Month, Day, Year)	32. Registr	rar's Signatu	re y	4)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34931 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:55P. 2. Date of Death Physician/ Lee Clark Lawrence October 23, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 210-22-6179 1**X** M 2 □ F 80 Days Hours Yrs Jűly15, 1931 Pennsylvania **Director** Usual Residence of Decedent 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's Adelphi 28a-f 1 ☐ Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 9808 Riggs Road 20783 United States Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items, any injury or other traumatic event, the Medical Examiner mu once. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1948–1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Divorced 4 Divorced Specify Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 gr 5+) Elementary/Seconday (0-12) Salesman retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Clark Elizabeth Dobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Berkowitz -friend 9808 Riggs Road Adelphi, Maryland 20783 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 10/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licenses Bonald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 haned 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fracture of Right Hip disease or condition Medical resulting in death) Due to (or as a consequence of): me Examiner mD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 0 Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 9 Unknown the. ed by the signed { Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6X Other (Specify) Hospice funeral 28a. Date of injury (Month, Day, Year) Aug • 29 • 2011 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred After ☐ Natural 5 Pending 8:00P. M 124 hours after death.

In Funeral Director: All pleted filled in by the fu Fell from standing position 2XX Accident 1 ☐ Yes 2 🗓 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify).
At home 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after
To the Funeral Direc 9808 Riggs Road Adelphi, MD 20783 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 only one Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title d certifier 29c. License number 29d. Date signed (Month, Dav. Year) D37142 October 25, 2011 30. Name and address of person who completed (ause of beath (Item 23a) (Type, Print)
G. Coleman, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855 31. Date filed (Month, Day, Year) - LV IV Registrar

Amend item Cecil CO H	#20-10-20-2011-vd ealth Dept Please Type or Print in B	lack Indelible Ink. Ensure All Copie	es Are Legible.					
	1 - State of Maryland State of Maryland	/giene Reg. No. 2011 34932						
Physician/	1. Decedent's Name (First, Middle, Last) Patricia A De Bow	2. Date of D Month	eath 3. Time of Death					
Medical Examiner	4a. Facility Name (if not institution, give street and number)  200 SPESUTIA ROAD	4b. City, Town, or Location of Death  ABERDEEN	4c. County of Death  HARFORD					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. (Month, D	rth 9. Birthplace (State or Foreign country)					
3	Usual Residence of Decedent /8	Yrs. MAY 18	3, 1933 KANSAS  10d. Inside City Limits					
he Maryland or 28a-f sho notified at Director	MARYLAND HARFORD  10e. Street and Number	ABERDEEN  10f. Zip Code	1 ☐ Yes 2 XNo					
leath with the rems 23a cer must be	200 SPESUTIA ROAD	21001	UNITED STATES					
0 2.5	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ※ Ves 2 □ No If Yes, Give Year or Dates. UNKNOW	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2X No Specify:	14. Race - American Indian, Black, White, etc.  Specify: BLACK					
21215-0036 within 72 hours after giene. er than "natural", o, the Medical Exam Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  CULINARY ARTS INSTRUCTOR	16b. Kind of Business/Industry  TRADE SCHOOL					
Maryland 2121 should be filed within 7 is marked other than raumatic event, the M To Be Com	17. Father's Name (First, Middle, Last) FRED WEBB	18. Mother's Name (First, Middle  LUCILLE ROBINS	,					
re, Maryland 1 and 2 should be filed 1 health and Mental H, item 27 is marked out other traumatic even	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Numb	er, City or Town, State, Zip Code)					
other trz	20a. Method of Disposition 20b. Place	200 SPESUTIA ROAD, ABERDEEN, Date	MARYLAND 21001  20c. Location - City or Town, State					
Baltimore, permit. Page 1 and Department of Her Important: If item any injury or othe once.	4 Donation 5 Other (Specify)	INGION NATIONAL 11/18/11	ARLINGTON, VIRGINIA					
Ba Depa Impo any ii	21. Signature of Funeral Service Licensee	22. Name and Address of Facility LISA SCUTT FUNERAL HOME 55 2 LEWIS STREET, HAVE	E, P.A. RE DE GRACE, MD 21078					
Physician/	23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cardi otherwise	ootic event	rrest, Approximate Interval Between Onset and Death					
Medical Examiner	Attacns (lent	ic cardiovascular Distant						
ecuted and Il-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
9 E isi								
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.  Medical Certificate: To Be Completed by Physician/Medical Exami	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnance 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	eath 3   Ectopic pregnancy	23d. Date of delivery Month Day Year					
IS, P.C uires that t n signed b uld be det	Part II. Other significant conditions contributing to death but not resulti		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
Division of Vital Records, P.O. all or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by 1 and in by the funeral director, page 2 should be detach.  I Certificate: To Be Completed by Physicians.								
ital ician: sertific ector,	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one)						
of Vi a Physi er this c eral dir	1 Inpatient 2 ER  27. Manner of Death 28a. Date of injury 28	b. Time of 28c. Injury at 28d. Describe	rsing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
ivision of or Attending P after death. Director: After t in by the funera	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	Injury work?  M 1 ☐ Yes 2 ☐ No						
Division of Vital   To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director, Medical Certificate: To Be (	building, etc. (Specify)	City or Tot	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
the Hospita nin 24 hours the Funeral npletely fille	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To T	29b. Signature and title of certifier  MS Ry up and M. D  30. Name and address of person who completed cause of death (Item 23 N.S. Rujupakse, M.D. 283 5  31. Date filed (Month. Day, Year)	29c. License number 00057465	29d. Date signed (Month, Day, Year)					
2	30. Name and address of person who completed cause of death (Item 23 ) 1. S. Rujky Pakte, M.D. 283 5	Smin A 5203 Baltime	12 MD 21709					
State Registrar	State of the state							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/11/2011 Shirley Barnhart Davidson 12:24 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days 02/21/1937 1 🗆 M 2 🔀 F 215-34-1927 **Director** MD 74 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 1769 Old Westminster Pike 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 XMarried 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 ☐ No Specify. White Completed 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Thomas Wilbur Barnhart Norma LaMotte 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shou of Health and item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan Davidson/husband 1769 Old Westminster Pk., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Sandy Mount Cemetery 10/15/2011 Finksburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami the burial-trar Due to (or as a consequence g Physician/Medical The law requires that the death certificate be attending phys I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Dav Pregnant at time of death signed by the at d be detached for g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No I or Attending Physician: after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSpital ( 200 Memorial

Registrar DHMH 17 Rev 7/2009 Year

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 24 October Margaret Louise Luraas Deitz Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death 4b. City, Town, or Location of Death Regional Hospita rince George aure 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 102-16-2648 1 □ M 2 🗓 F NewTork Director 88 Usual Residence of Decedent or 28a-f shov 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Prince George's Silver Spring 1 🗆 Yes 2 🄀 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3160 Gracefield Road, #1503 20904 United States "natural", or items 23a permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Occupational Therapist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernett Ames Ruth Nipper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Louise Deitz Stancliff -daughter 6301 Gabriel Street Bowie, Maryland 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crematory10/26/2011 Alexandria, Virginia 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Porald V:ss Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intracerebra Onset and Death Hours Immediate Cause (Final Physician Medical resulting in death) Examiner Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last and use as the burial-trai Due to (or as a consequence of) attending physician the Hospital or Attending Physician: The law requires that the death certificate be eithin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia mpleted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【\*Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 NInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and 29d. Date signed (Month, Day, Year) D24035 October 25, 301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring 20904 Road Gracefield Machado. 3110 31. Date filed (Month, Day, Year) -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Goldie May Davis Physician/ October 26, 2011 6:28 AM M Medical 4a. Facility Name (if not institution, give street and number)
Kline Hospice House 4b. City Town, or Location of Death Mt. Airy **Examiner** 4c. County of Death Frederick 8. Date of Birth (Month, Day, Year) April 27, 1921 . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 213-42-1737 90 Director 1 🗆 M 💥 F Maryland 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Frederick Frederick 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9481 Pocono Drive 21702 "natural", or items 23a U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph E. Jenkins Lydia Irene Pearl <sup>19a.</sup> Informant's Name/Relationship *(Type, Print)* Mrs. Juanita D. Slater, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9481 Pocono Drive, Frederick, MD 21702 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Mount Olivet Cem. Oct. 29, 2011 Frederick, MD 4 Donation 5 Other (Specify) 21. Signatur o Finaral Service 2. Name and Address of Facility Leeney and Basford PA Funeral Home 06 East Church St., Frederick, MD M00255 23a, Part 1, Enter the disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ pulation Medical Examiner 12915 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery jo in the past 12 months?

1 Yes 2 No Month Day Year should be detached Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No To the Hospitar or within 24 hours after death.

To the Funeral Director: After this certificate mannetely filled in by the funeral director, par To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) <del>louse</del> 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

21716

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October William Dallas Elliott, Jr. 201<sup>Teal</sup> 3:45  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Center Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth March 6, 1945 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours Director 213**-**48-3828 66 Maryland Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or items 23a or 28a-f Maryland Dorchester 1 🗆 Yes 2 🛛 No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5128 Paw Paw Road 21613 USA . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Baltimore, Maryland 21215-0036 Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dentist Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) William Dallas Elliott, Sr. Matilda Tobat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Elliott/Wife 5128 Paw Paw Road, Cambridge Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Old Trinity Ch. Cem. 10/21/2011 Church Creek, Maryland Name and Address of Facility Ter Funeral Home, P. O. Box 207 6 Main Street, East New Market, Maryland 21631 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death -Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions. Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi signed by the attending physician and deetached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Day 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No Vithin 24 hours area. \_\_\_\_
To the Funeral Director: After this ....
---lated filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Sompleted f (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of

Registrar DHMH 17 Rev 7/2009

State

of person who completed cause of death (Item 23a) (Type, Print)

20

29d. Date signed (Month, Day, Year)

		Please	Type or Prin							gible.			
	-	For State Registrar	State of Ma	-	•	tment of Fi ficate of D			leg. No.				
Physicia	n/	1. Decedent's Name (First, Middle, Las	•	(MDD				2. Date of Dear Month OCTOBER	15, <sup>2</sup>	3. find of theath 7 2011 1:45 P M			
Medic Examin	al	GLYDON BURNETTE N 4a. Facility Name (if not institution, give		TEP		4b. City, Town, or	Location of Death	OCTOBER	4c. County of Death				
/		CIVISTA MEDICAL C		the up last high	day	LA PLA	TA  If Under 24 Hrs.	8. Date of Birth		CHARLES  9. Birthplace (State or Foreign			
Funeral Director		5. Social Security Number 6. S 215–14–7530	M 2 STF	(In yrs. last birth		Months Days	Hours Min.	AUGUST 9		MARYLAND			
nd thow at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Local	tion			10d. Inside City Limits				
Maryla 28a-f s otified	irect	MARYLAND CHARLES		POMFRE:	Γ					1 🔀 Yes 2 □ No			
ith the	Funeral Director	10e. Street and Number  9540 BLUE LAKE PI	ACE			10f. Zip Code 20675				of What Country?  STATES			
items	Fune	11. Marital Status	12. Was Decedent Ev		13. Wa	s Decedent of Hi	spanic Origin? (Spanic Origin? (Spanic Origin?)	ecify Yes or No-	14. Ra	ace - American Indian, lack, White, etc.			
al", or	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates.	No		☐ Yes 2 🛣 No				ify: BLACK			
2 hours "natur edical l	plete	15. Decedent's E (Specify only highest gr	ducation		(Give kin	ecedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired)							
vithin 7 jiene. er than the M	To Be Completed	Elementary/Seconday (0-12)  8TH GRADE	College (1-4 or 5-	+)	COOF				HOTEL INDUSTRY  aiden Surmame)  R MARSHALL  City or Town, State, Zip Code)  MARYLAND 20675				
filed value of tall Hyg		17. Father's Name (First, Middle, Last)	MADCHATT				18. Mother's Nam						
ould be nd Men marke imatic	1	LAUREL LAGUARDIAN  19a. Informant's Name/Relationship (7)		19b.	Mailing	Address (Street a							
nd 2 sh ealth ar m 27 is ner trau		JAMES W. ESTEP /	GRANDSON	95	40 I	BLUE LAK			, MARY	LAND 20675			
ige 1 ar nt of Ha t: If iten		20a. Method of Disposition  1 X Burial 2 Cremation 3 C			y, c <i>r</i> ema	tory or other plac	e) [	Date		on - City or Town, State			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Licen		IKINITI		RTAL CARDS	as of Facility UNERAL HO			TARTLAND_			
P S E E S		LYDIA C. THORN  23a. Part 1. Enter the disease, or com	<u>ron Johnson</u>		<u> 134:</u>	<u> 39 LIVIN</u>	<u>GSTON ROA</u>	<u>AD, INDL</u>	<u>AN HEA</u>	D, MARYLAND 20640			
· Physician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line	nn	(h)	les no	O. A. C.	, , , , , ,	,	Interval Between Onset and Death			
Medical Examiner		resulting in death)	Due to (or as a	consequence o	n:	7	W.V~						
	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of)											
ecuted and I-transit	xamine	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.											
be exe slcian a burial-	ш	resulting in death) Last	Iting in death) Last Due to (or as a consequence of):										
tificate ng phy: as the	Completed by Physician/Medical	IF FEMALE:											
ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	2 🗌 Fetal death		Ectopic pregnand Other (specify)	у			Date of delivery Month Day Year			
the de by the tached	Physi	9 🗌 Unknown	9 🗌 Unknown				in Death			1 Clark As As As a second depth 2			
res that signed	d by I	Part II. Other significant conditions of	contributing to death bu	ut pot resulting in	n the und	derlying cause giv	ven in Part I.			ontribute to the cause of death?  O 3-12 Probably 4   Unknown			
v requii s been s should	olete	81	9 7 5					24a. Was a		b. Were autopsy findings available prior to completion of cause of			
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ng Phy fter this ineral d	ate: To	27. Manner of Death  1 X Natural 5 Pending	28a. Date of injur (Month, Day	y 28b. T	•	28c. Injur work	y at	28d. Describe h					
Attendii death. ctor: Ai y the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not I	be 28e Place of Inju	ry - At home, far	m, stree		Yes 2 No	28f. Location (S	treet and Nur	mber or Rural Route Number,			
ital or / irs after al Direced in b		4 ☐ Homicide determined	building, etc	. (Specify)				City or Tow	n, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	ysician: To the best of on niner: On the basis of ex rse Practioner: To the l	kamination and/o	r investic	ation, in my opinio	on, death occurred a	at the time, date a	nd place, and	due to the cause(s) and manner stated			
To th∉ within To th∈ compl	Σ	29b. Signature and title of ertifier	10. 1 km	DOGE OF THE KHOW	- 430, 46	29c. License				ned (Month, Day, Year)			

State

MICHAEL A. LEATHERWOOD, M.D. 12070 OLD LINE CENTER, SUITE 302, WALDORF, MD 20604

31. Date filed (Month, Day, Year) 2011 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of ertifier

Registrar

D21031

OCTOBER 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryl				Mental Hyo	giene				
	-		Registrar  1. Decedent's Name (First, Middle, La	ast)	Cer	Certificate of Death  Reg. No. 2  2. Date of Death 14  3. Time							
Н	Physici Medi		Camille Cottrel	,				Month	Death 14 3. Time of Death 1:50 PM				
ration,	Exami		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death		4c. County of Deat	12.50			
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	Funeral Director			1 □ M 2 <b>X</b> F	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h 9. Birl v, Year) Coa	hplace (State or Foreign untry)			
		1	579-38-4494 Usual Residence of Decedent	86				Dec. 11	. 1924 D.C	•			
	yland •f sho ed at	향	10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limits			
	r 28a notifi	Director	Maryland Howard  10e. Street and Number	Co	lumbia	1				1 X Yes 2 No			
	vith th			na Danilaran		10f. Zip Code			10g. Citizen of What Co	,			
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36	ifter d ", or i	۾	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give		Yes, specify Cubar  Yes 2 No		Rican, etc.)	Diack, Write, etc.				
0	is filed within 72 hours after death with the Maryland tal Hygiene.  3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	3 Widowed 4 X Divorced  15. Decedent's	Year or Dates.					Specify: Afri	rican			
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Ž	ould b id Mei mark matic		C. James Cottrel  19a. Informant's Name/Relationship (				Mary Ell						
Ma	12 shallth ar 27 is rtrau		Denise Woods/Repr	<i>3.</i>	3220 (	Address (Street ar Chestnut	nd Number or Run <b>Street,</b>	al Route Number, North We	City or Town, State, Zip <b>2st</b> <b>Dia 20015</b>	Code)			
ore,	age 1 and 2 should be file ent of Health and Mental H It: If item 27 is marked or y or other traumatic ever		20a. Method of Disposition	201	<ul> <li>Place of Dispos</li> </ul>	ition (Name of atory or other place		Date Date	20c. Location - City or	Town, State			
<u>ti</u>	. Page ment tant: I jury o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ncoln Ce		:	4/2011 5	Suitland,Ma	ryland			
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t		21. Sprature of Funeral Service Licer	Frank	74( Va	Name and Address OG Georgi	of Facility McG a Avenue District	uire Fu North V	neral Servi West umbia 20012	ce, Inc.			
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused the de	eath. Do not enter	the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between			
	Physician/ Medical	i ()	Immediate Cause (Final disease or condition	Alzheimer'	s Diseas	se				Onset and Death <b>Years</b>			
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89	or Attending Physician: The law requires that the death certificate be executed after death.  Director, After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. Date of deli	ven			
Division of Vital Records, P.O. Box 68	death ne atte ed for	sicia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fe 4 Pregnant at time o		Ectopic pregnancy Other (specify)			Month	Day Year			
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Sec	sician: The law certificate has be irector, page 2 s	Completed						autops perforr	med? prior to c death?	ompletion of cause of			
E .	ysician: is certifica director, p	Be C	25. Was case referred to medical examiner?			26. Plac	e of Death (Check	1 Yes :	Z No I Yes	2 No			
<u> </u>	Physi this c	<u>1</u>	1 ☐ Yes 2 🗷 No 27. Manner of Death	Hospital: 1 Inpatient 2 2 28a. Date of injury	ER/Outpatient 28b. Time of		4 L Nursing Ho		ence 6 X Other (Specia	Assisted by Living			
ם מ	nding Ph tth. ; After thi e funeral	cate	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury a work? M 1 🗌 Ye	es 2 □ No	28d. Describe ho	w injury occurred				
	II or Attendii s after death. Director; Af d in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		nome, farm, stree				reet and Number or Rura	al Route Number,			
בֿ ;	urs aft ral Dii lled in	- 1						City or Town					
:	the Hospital or thin 24 hours aft the Funeral Dir mpleted filled in	Medica	(Uneck 2 L Medical Exam	sician: To the best of my kno	on and/or investig	ation in my opinion	death occurred at	the time date and	d place, and due to the e	nuco(a) and manner states			
:	Thin 2	Σ	only one) 3 L Certifying Nurs	se Practioner: To the best of r	my knowledge, de	ath occurred at the t 29c. License r	ime, date and plac	e, and due to the	cause(s) and manner as s 9d. Date signed (Month,	stated.			
	100		•		MD	D5653	1		October 17,				
		Ì	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Prii								
	- Charl		Harry Li, M.D. 8	600 Snowden R			ite 301,	Columbi	ia, Maryla	nd 21045			
	Stat Registra	9	OCT 18 2011	82. Registrar's Sign	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Emerick** John Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-RMC Cumberland 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Min. Country)PA Dec 22, 1928 Director 728-01-7112 82 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 XYes 2 No 10e, Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 901 Seton Drive 21502 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
Intent of Health and Mental Hygiene.
Intent if item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced Korea Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clerk B & O Railroad event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Emerick Josephine Edwards 19a. Informant's Name/Relationship (Type, Print)
Daniel Klavuhn 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Codel 701 Princeton Street Cumberland MD 21502 cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. Davis Memorial Cemetery 10/28/20 Cumberland MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lo 22. Name an**Scarpein Faitheral Home**, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each lin Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). the attending physician and hed for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe c 1 Yes 2 No 3 Probably 4 Unknown phods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law has autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 ANO ည 1 ☐ Inpatient 2 ☑ €R/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to din by the funeral 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1- Natural 5 Pending М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours at the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated petitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year)

200

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 02

D0033280

M.D. 625 Kent Ave. Ste. 101 Cumberland, IND

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#4a, b, perPHYS, G921, T1/2/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month /U OVU 1046M Medical Ballimore Washington Medical Center Examiner 4b City, Town, or Gration of Beath 1e 4c. County of Death Anneavunde 000 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F 94 Dec Pay, Year 1916 **Director** 216.09.4174 Maryland Yrs Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits Director 10c. City, Town or Location MD Baltimore Catonsville 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 204 Glenmore Ave. USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 X Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) MD StateMass Transit Elementary/Seconday (0-12) College (1-4 or 5+) Comptroller Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Washington Everly Gertrude Stotelmyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Son 702 Severnside Ave. Severna Park, MD 21146 Dr. George Everly Ir 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Good Shepherd Cemetery 10/29/2011 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ellicott City, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funera Signature of Funeral Service Licensee Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 MOIOST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Ulti Physician/ Org stem an disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or us a consequence or) cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day been signed by the should be detached 1 L Yes 2 L q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an : after death. I Director: After this certificate has ا التعديد التعد autopsy performed?

1 Yes 2 No 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 ☐ Yes 2 ☐ No \_\_ Accident Investigation 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) FC2153891 10/3/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 2007 Tidewater Calony Dr FIA, Amapolus MD enviter lark 31. Date filed (Month, Day, Year) NOV 0 1 2011 32 Registrar's Signatur State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34941 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October October Ray Emerson Fair 11, 2011 12:47 a M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 213-24-7643 Director 83 sep 4 ay, T928 Maryland Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Examiner must be notified Carroll Taneytown Maryland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral items 23a 3600 Baptist Road 21787 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give 0 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 "natural", 3 🗌 Widowed 4 🗌 Divorced 1 ☐ Yes 2 No Specify: Completed Specify: white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working marked other than Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Manufacturing Factory Worker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Fair Grace Copenhaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Fair, wife 3600 Baptist Road, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State South crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/11/2011 Winfield, MD Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEBILITY disease or condition resulting in death) SEMILE Medical Examiner CHROPIC KIDNEY DISEASE (585.9 Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine The law requires that the death certificate be executed ARTER103CLER0313 and the burial-tran that initiated events resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv Director; After this certificate 2 🗌 No 1 Yes Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♣No Be 26. Place of Death (Check only one) မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 -Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1.X.Natural 5 Pending Accident work 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, careful anomaly as the time, date and place, and due to the cause(s) and finance as stated. (Check 29c. License number m-R. Linthoum, M. D October 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wm. R. LINTHICUM, M.D. ONE KINGS DRIVE, TANGYTOWN, MD 21787

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

OCT 1 2 2011

back

32. R/ istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34942 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 18 20<sup>Yea</sup>1 4:30 Austine Rae Fink Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7680 Carley Drive Charles Port Tobacco Social Security Number 8. Date of Birth
(Month, Day, Year)
Aug. 23, 1953 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 1 M 2 F Months Hours Min. Washington D.C **Director** 58 068-46-3873 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Charles Port Tobacco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 7680 Carley Drive 20677 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates and Mental Hygiene. 1 ☐ Yes 2 👿 No Specify. White Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Art Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John James Miles June Victoria Millholland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Roger Fink/Husband 7680 Carley Drive Port Tobacco, MD 20677 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Page 1 ō 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 10-20-2011 Charlotte Hall, MD Brinsfield-Echols 22. Name and Address of Facility Arehart Echols Funeral Home, P.A. Signature of Juneral Service M01458 St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician car disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Month Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? after death.

Director: After this certificate has autope, performed : 2 No ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: ျ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) in by the funeral 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending Investigation Accident 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18

DL

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

P.O. Box 2729 La Plata, MD 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				aryland / Depa	artment of H	ealth and	Mental Hyg	giene		
			State Registrar	Cei	rtificate of D	eath	Reg. No. 20	1 34943		
	Physicia	an/	1. Decedent's Name (First, Middle, Last)  Karen Lyn Floyd				2. Date of Dea Month	Day Yea	3. Time of Death	
	Medi Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Looption of Dag			23:40 P <sup>™</sup>	
10,000	LAdiiii	ici	Southern MD Hospital		Clinton		4c. County of De	George's		
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	9. 1	Birthplace (State or Foreign		
	Director		216 78 3730 1 DM 2 TF	53 Yrs.	Months Days	Hours Min	Year) R 1958 F	Country) Lorida		
	at at	'n	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	Maryla 18a-f tiffed	Director	Maryland Prince George's	Fore	stville				1 ☐ Yes 2 VYNo	
	a or 2 be no		10e. Street and Number	rore	10f. Zip Code			10g. Citizen of What		
	th with ms 23 must	Funeral	2742 Lorring Drive #103			20747		United Stat	tes	
10	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho dedical Examiner must be notified at		11. Marital Status 12. Was Decedent I Armed Forces?	li li	Was Decedent of His f Yes, specify Cuban	panic Origin? (S , Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi	merican Indian,	
21215-0036	safte ral", d Exam	ed by	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X If Yes, Give Year or Dates,	No 1	☐ Yes 2 XX	Specify:		Specify:		
5-0	hour "natu dical	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done du	tion		African American  16b. Kind of Business Industry		
121	within 72 giene. er than , the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5	DOE						
	filed wit al Hygie d other vent, th	BeC	12 17. Father's Name (First, Middle, Last)	(1	Unemployed)			DOE		
Maryland	should be file h and Mental I 7 is marked o raumatic eve	일	Grady Floyd			_	me (First, Middle, M Quintyne	Maiden Surname)		
ary	hould and M s mar umat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	a Address (Street ar		-	City or Town, State,	Zin Code)	
	id 2 si saith s n 27 i		Grady & Fay Floyd (Parents)	1	5 Castle Dri			-	zip odde)	
Baltimore,	e 1 and of Heal of Item 3 if item 3 ir other		20a. Method of Disposition 1XX Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos			Date	20c. Location - City	or Town, State	
Ę	t. Page tment o tant: If jury or		4 ☐ Donation 5 ☐ Other (Specify)	Resurrection	on Cemetery	10/1	9/2011	Clinton, MD		
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licensee	7 50 22	Name and Address Ferry Road	of Facility Lee Clinton	Funeral 1 MD 20735	Home,Inc 663	3 Old Alexandria	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente				est,	Approximate	
F	h sician/	8 8	Immediate Cause (Final disease or condition	al Con	diac	AIST	thenic	1	Interval Between Onset and Death	
	Medical Examiner		resulting in death)  Due to (or as a	consequence of):	- 1					
	122	Jer.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	a consequence of):	9114/6					
	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	DRI AR	15h1					
	execu an an	Ë	that initiated events c. Due to (or is a	consequence of):	21 000					
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687	certificate be executed nding physician and use as the burial-transi		IF FEMALE:							
Box	v requires that the death certific been signed by the attending I should be detached for use as	by Physician/M	in the past 12 horitis:	2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year	
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л О	rnar r ned b e deta	Ž	Part II. Other significant conditions contributing to death but	ut not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute	to the cause of death?	
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Vital Records,	aw rei as be 2 shc	Completed					24a. Was ar autops		autopsy findings available o completion of cause of	
e Y	cate h	5					perform	ned? death?		
<u>.</u>	certific ector,	m	25. Was case referred to medical examiner? Hospital:		100	e of Death (Che				
ا ا	r this ral di	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of injur	nt 2 ER/Outpatient				nce 6 Other (Spe	əcify)	
מו	ath. :: Afte e fune	Certificate:	1 Natural 5 Pending (Month, Day, 2 Accident Investigation		28c. Injury a work? M 1 🗆 Ye	es 2 🗆 No	28d. Describe ho	w injury occurred		
VISION	er dez rector by th		3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injur	ry - At home, farm, stree				reet and Number or F	Rural Route Number,	
<u>ב</u> ּ			building, etc.				City or Town			
200	Fune Fune	Medical	29a. Certiffer (Check 2 Medical Examiner: On the basis of ex	amination and/or investig	gation, in my opinion	death occurred	at the time date and	I place and due to the	e cause(s) and manner stated	
cht ch	vithin To the		only one) 3 Certifying Nurse Proctioner: To the beginning on the beginning of the beginning	pest of my knowledge, de	eath occurred at the t	ime, date and pla	ace, and due to the	cause(s) and manner a 9d. Date signed (Mor	as stated.	
	7 - 0		Brellehal W		DC	2200		10-13-//		
	2 DC		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, Pri	int)	120		00/15/11	1	
2	, , ,		Wandell Lierson 75	03 SILIT	atts P	d. C.I.	inton.	Ma 20	735	
	State Registra		1. Date filed (Month, Day Year) 2011 22. Registrar	's Signature	16					
	negistra		No.	la . The said						

11-07751 Gregory Ford

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

egory Ford		1- For State Amend#18perf	ate of Marylan uneralhome10	nd / Dep /20/1⊊6	oartment o e <i>rtificat</i> e o	of Health an of Death	d Mental		Reg. No. 20	Marine Ma	3494
Physici Medical Exami	an/ ine	Decedent's Name (First, Middle Gregory Allen     4a. Facility Name (if not institution Control of the Cont						2. Date of Do			3. Time of Death 0036 hrs
		Prince George's Hospi	n, give street and numb tal Center	ber)		4b. City, Town, or Cheverly	Location of Dea	ath	4c. County of Prince G		s
Funeral Director		5. Social Security Number 229 94 6081	6. Sex 7.	Age (In yrs.	last birthday) 53 <sub>Yr</sub>	If Under 1 Yea  Months Days s.			3/1958	Foreign	
any		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loca	ation				<u> </u>	10d. Inside City Limits
laryland <b>:8a-f show</b> at once.	ţo	MD st. M	ary's	Le	xingto	on Park					1 X Yes 2 No
the Mary a or 28a	Director	10e. Street and Number 21284 Mayfair	e Lane Uı	nit 1	04	10f. Zip Code 20653			10g. Citizen of Wh	at Countr	у?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Ma	1 A Yes	es?	lf'	as Decedent of His Yes, specify Cuban	panic Origin? ( , Mexican, Puer	Specify Yes or N to Rican, etc.)	lo- 14. Race White		an Indian, Black,
ırs after hural", o	Š		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Wor								
5-0036 led within 72 hours a Hygiene. I other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4		during n	nost of working life.	DO NOT use re	etired)			
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than umarke event, the Medical		12th 17. Father's Name (First, Middle, I	.ast)		Air C	raft Me		ne (First, Middle	U.S. G Maiden Surname)	ove	rnment
21215-0 ould be filed w I Mental Hygie in marked othe ic event, the M	o Be	Bernard Ford  19a. Informant's Name/Relationshi			19h Mailin	n Address (Street		Norr	ell mber, City or Town	Ctata 7	Zin Codo)
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If then 27 is n injury or other traumath	_	Christopher 1	, , , ,		4941	Olympia	Place		orf, MD	206	02
NOFE, ages 1 ar at of Hee		20a. Method of Disposition  1 Burial 2 Cremation		State	crematory or ot			Date	20c. Location - 0		
Baltimore, permit. Pages 1 an Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Spe 21. Signature of Funeral Service L		Qu	antico	Nat'l Name and Address	Cem 10/ of Facility Br	24/201 iscoe-	Tonic F	une	, VA ral Home
D ឧក្សារ Physician		23a. Part I. Enter the disease, or co	omplications that caus		22	194 Old	Washir	igton F	d.Waldo	rf,	MD 20601
/Medi_l Examiner	N	Immediate Cause (Final disease	n each line.		juries	ne mode or dying, s	ouch as cardiac	or respiratory ar	rest, shock, or hear		Approximate Interval Between Onset and Death
	ı	or condition resulting in death)  Sequentially list conditions,	Due to (or as a cor b.	nsequence d	of):					$\neg$	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cor	nsequence o	of):						
uted id ansit		events resulting in death) Last	Due to (or as a cord.	nsequence o	of):						
60, nte be exec nysician ar	Nedical	X UNPENDED	AMENDED 2			per me g	921 11-	3-11 <b>vt</b>			
Sox 6876 leath certificate e attending phy for use as the b	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc		2 Fe	tal death 3	Ectopic pregn	ancy	23d. Date of d Month	elivery Day	y Year
Box 687 e death certifica the attending pi ed for use as th	Physician/N	1 Yes 2 No 9 Unkno		at time of de	eath 5 Ot	her (Specify)					
P. P. S that s that gned I	<u>۾</u>	Part II. Other significant condition	ns contributing to dea	ath but not r	esulting in the u	inderlying cause give	ven in Part I.		obacco use contrib		
ords, w require s been si should b	Completed							24a. Was	an 24b. W	ere autop	osy findings available
of Vital Records, ng Physician: The law requir Wher this certificate has been a meral director, page 2 should	E O								orm <u>ed</u> ? de	ath? ✓ Yes	2 No
certicos certicos	L Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpat	tient 2	ER/Outpatient		of Death (Check	only one)	Residence 6	Other:	
_ 4 . ~ 2		27. Manner of Death  1 Natural 5 Pending	28a. Date of In (Month, Day	njury ,Year)	28b. Time of Ir			28d. Describe	how injury occurred		
Division tall or Attendir is after death.  All Director: A led in by the fu	Certification:	2 X Accident Investig 3 Suicide 6 Could r	ation 10-13-		7:59pm ome, farm, stree	t, factory, office bui	s 2 X No	28f. Location (	Street and Number	or Rural	y an auto Route Number, City
Ospital ospita		4 Homicide determi	ned (Specify)	roa					State) 21367 cington Pa		at Mills Md.
Division of  Division of  To the Hospital or Attending Pl within 24 hours after death, completely filled in by the funeral	10	(Check only	ician: To the best of r ner:On the basis of ex- and manner stated	amination a	ge, death occurr nd/or investigati	ed at the time, date on, in my opinion, o	e and place, and death occurred	d due to the caus at the time, date	se(s) and manner a and place, and due	s stated. to the ca	ause(s)
	Σ	29b Signature and title of certifier	-5)/1/	208	Ð	29c. License O.C.M			29d. Date signed October 17,		Day, Year)
(11)	4	30. Name and address of person wh	o completed cause of	death (Item	23a)	J.O.IVI			Colober 17,	2011	
Sta	0		Assistant Medica	al Examin		. Baltimore Str	eet, Baltimo	ore, MD 2122	23		
Registra	ar	31. Date filed (Month, Day, Year).	4 711711 77.	an s Signatu	A. 19	MAN		<u></u>			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 2011 9:29 FLYNN CHARLES Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Days Hours Min Feb. 23, 1931 80 Tennessee 218-24-6239 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location the Maryland Director 1 Yes 2 No notified Silver Spring 28a-f Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ö must be United States Funeral 20904 23a 3320 Kilkenny Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ò þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Heatht and Mental Hygiene.

The 127 is marked other than "natural", or any file me 27 is marked other than "natural", or other traumatic event, the Medical Examin ury or other traumatic event, the Medical Examin altimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Korean War Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0112) College (1-4 or 5+) self employed Builder Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruby Gann Frederick Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3320 Kilkenny Street Silver Spring, Maryland 20904 Iona Cleopatra Flynn -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
George Washington Carretery 10/25/2011 Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signatur Funeral Pervice License Bonald Aves Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine onsequence of Cause (Disease or linjury that initiated events and burial-tran resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No or 5 Other (specify) Pregnant at time of death been signed by the s should be detached t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 28b. Time of 28d Describe how injury occurred Certificate: 1 Natural 28c. Injury at iniury work? 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one)

State Registrar 29b. Signature and title of certifie

NOV

Name and address of person who completed cause of death (Item 23a) (Type, Print)

7th St

Frederick, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death  $^{\text{Month}}0$ Physician/ 20 Î Î 12:00P M Ellen S. Graham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 310 Warburton Road E1kton If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Min. (Month, Day, Year) Country Hours 216-30-9952 Director 76 1 M 2 X F 8/15/1935 WV Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location death with the Maryland at Director notified 1 Yes 2 X No MD Ceci1 ELkton 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral Examiner must 21921 USA 310 Warburton Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black White etc "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify White 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. 12 Assembly Worker Auto Manufacturing other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) n and Mental I မ Julia Etelle Roy Matney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 2030 Flagstone\_Court, Abingdon, MD 21009 Barbara Graham - daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/2011 Rising Sun, MD Friends Cemeterv 21. Signature of Fund at Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, PA 'nι Queen Street, Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 0 Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Day Year Month 2 No the 9 \ Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Residence 6 Other (Specify) within 24 hours after ucca...

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural 5 Pending work 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

ddress of person who completed cause <u>of</u> death

ARDDN

220-56-7426   1.   10.	lace (State or Foreign try) Land  Od. Inside City Limits  1  Yes 2 X No  try?  S  an Indian,  tec.		
Long View Nursing Home  Under the color of t	lace (State or Foreign try) Land  Od. Inside City Limits  1  Yes 2 No  try?  S  an Indian,  tec.  telegraphy		
Section   Sect	land  Od. Inside City Limits  1 □ Yes 2X No  try?  S  an Indian, etc.  te		
10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10d. Marchester   10d. Zip Code   21102   United States   11. Marital Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)   14. Race - Americal Hives, Specify Cuban, Mexican, Puerto Rican, etc.)   12	1 □Yes 2X No  try?  S  an Indian,  etc.  te  dustry		
3913 Millers Station Road  21102  United States  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rician, etc.)  14. Race - Armedic Black, White, e Specify: White, e Specify	an Indian, etc.  te		
Specify: Whites and the part of the part	etc. te dustry		
Special New Yorker   Special	What Country? States  e - American Indian, k, White, etc.  white  sisiness/Industry  l needs  pp  e)  State, Zip Code)  C, MD 21102  City or Town, State  sville, Maryland  me		
17. Father's Name (First, Middle, Last) Richard W. Grier  19a. Informant's Name/Relationship (Type. Print) Elizabeth B. Weber / sister  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Elizabeth B. Weber / sister  20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  M01072  22. Name and Address of Facility Eline Funeral Home M01072  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sequentially list conditions, if any leading to not respiratory of the place of Disposition (Name of cometery crematory or other place) Union Cemetery  22c. Name and Address of Facility Eline Funeral Home M01072  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited late Cause (Final disease or conditions, if any leading to not reported by the conditions, if any leading to not reported by the conditions, if any leading to not reported by the conditions, if any leading to not reported by the conditions, if any leading to not reported by the conditions are consequence of):			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, legaling to hypercate.			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  b. Club to (or as a consequence of):			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, legating to immediate the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Due to (or as a consequence of):			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):	yland 21074		
Sequentially list conditions, if any, legaling to hympotate  b. Curelinal Pally  Due to (or an a nonnecount of):	Interval Between		
Cause. Enter Underlying Cause (Disease or injury that initiated events Testulting in death) Last  Due to (or as a consequence of):	64 yrs		
Bue to (or as a consequence of).	<b>,</b>		
IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy 23d. Date of delive	ery Day Year		
Farth. Other significant conditions contributing to dealin but not resulting in the underlying cause given in Part i.	ne cause of death?		
autopsy prior to cor			
performed?   1   Yes   2   No	psy findings available mpletion of cause of 2 □ No		
Yes   2   No	mpletion of cause of 2 □ No		
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   I   Inpatient   2   EP/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other (Specify North)   Other:   4   Nursing Home   5   Residence   6   Other	mpletion of cause of		
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.	mpletion of cause of 2 □ No  y)		

To the Hospital c within 24 hours af To the Funeral D completely filled in

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

OCT 1 4 2011

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 7 per DVR G921 11/4/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death Decedent's Name (First, Middle, Last) 10:05 Physician/ Ctoper Bryce D. Griffin Medical 4b\_City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** paltimore The Johns HOPKINS HOSPITAL 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) al Security Number 6. Sex **Funeral** Months Hours Min. **Director** Unknown 1 M 2 X F 3 19 Yrs. Maryland 14, 2011 Usual Residence of Deceden 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director must be notified Yes 2 No Maryland Charles Indian Head 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number 23a Funeral 20640 U.S.A. 7 Greenwood Place "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. ş 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ▼No Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 2 should be filed within 72! th and Mental Hygiene.
7 is marked other than "n life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) N/A N/A other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Allen Griffin Regina Raby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 7 Greenwood Place, Indian Head, Md. 20640 Father Allen Griffin 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 19, 2011 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Waldorf, Maryland Trinity Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sep 22 Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYB PLACIA SEVERE PULMONAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Stlo CK physician and the burial-trans Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death the a 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 perform death? within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) B B Other: 1 🗌 Yes 2 X No 1 Ninpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d Describe how injury occurred Certificate: injury 1 Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 N- Wolfe St. Battimore, ModDe KESMVAN 31. Date filed (Month, Day Year) egistrar's Signature State 2011 18 Registrar MULL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Wilfred Lacy Goodwyn October Medical 2011 10:10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8911 Burdette Road Bethesda Montgomeru Funeral Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Richmond, Virginia 1 **X** M 2  $\square$  F Months Days Hours **Director** 563-58-4490 May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nother 1" any or other trainer." 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No Maryland Montgomeru Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8911 Burdette Road 20817 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Investment Manager Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wilfred Lacy Goodwyn Elizabeth Lee Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Goodwyn, Spouse 8911 Burdette Road, Bethesda. Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 10/18/2011 Brentwood, Maryland 21. Signature o Funeral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike. Rockville. Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate
Interval Between
Onset and Death
5 UCATA Immediate Cause (Final Physician/ disease or condition Non-Hodgkin Lymphoma years -Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year the s g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) 2**X** No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No the f Accident Investigation after death Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

30

29b. Signature and title of certifier

Vera Malkovska,

OCT

31. Date filed (Mont)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18 2011

110 Irving Street NW,

29c. License number

MD 21030

Washington, DC 20010

October 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Oct<u>ober</u> 201 :59 Arthur Lionel Gamson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** <u>Suburban Hospital</u> Bethesda Montgomery If Under 24 Hrs 7. Age (In vrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** New York Months Hours Min. 05/08/191 1 🕅 M 2 🗆 F Yrs Director 94 133-05-0359 Usual Residence of Dece 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at with the Maryland Funeral Director 1 X Yes 2 □ No Friendship Heights MD Montgomery 10g. Citizen of What Country? ö 10e. Street and Number 23a Apt.# 604west 20815 4620 N. Park Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. 1943 ò þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 1945 "natural", Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Technical Reserch <u>Librarian</u> ulth and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ments Important: If item 27 is marked any injury or other transmone. မှ Irene Horlick Gamson <u>Nathan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Takoma Park, MD 7318 Piney Branch Rd. Neil Gamson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) **Judean** 4 Donation 5 Other (Specify) 10/14/2011 <u> Memorial Gardens</u> Moly 722. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville, MD 20852 Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of). resulting in death) Last ding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 X No ပ္ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) X Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5  $\square$  Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0070027 October 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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11/01/01

8600 01d

2. Registrar's Sign

Haizia Amsler M.D.

Date filed (Month, Day, Year)

18 2011

Georgetown Rd. Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DC1 8:46 Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 0) Manland Machical timore Social Security Number **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours Min 214-30-8809 Aug 1933 Director Maryland 78 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Kent Still Pond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13246 Still Pond Rd. 21667 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc Baltimore, Maryland 21215-0036 1 Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Environmental & Safety Supervisor 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Elmer Gorsuch Elizabeth Mary Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code (wife) 13246 Still Pond Rd. Still Pond, MD. 21667 Genevieve Gorsuch 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 Donatie 5 🗌 Other (Specify) Kent Cremation Services 10/31/11 Smyrna, DE. 21. Sign --<sup>22. Name and Address of Facility</sup>
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death Sepsis due disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): If any leading to immedicause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page perform Yes To the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No Hospita 1 Tes မြ Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident Investigation 1 🗌 Yes 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 29d. Date signed (Month, Day, Year, 740597038 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V

DHMH 17 Rev 7/2009

State Registrar Catharina

31. Date filed (Mo.

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34952 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year HARMON CHARLOTTE RUTH 2011 1107A 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER WESTMINSTER CARROL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 🖹 Months Hours 218-54-2791 Director 62 10/24/1948 Usual Residence of Decedent fshow 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f Carroll MD Westminster 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral filed within 72 hours after death with 906 Old Manchester Rd. 21157 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Black. White, etc 1 Never Married 2 Married Completed by Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white "natural", 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>sales administration</u> <u>Universal Security</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank August Morgan Maude Evelyn Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Harmon daughter 3400 Eastern Blvd J13, York, PA 17402 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation 10/13/2011 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Lemmer Main St., Hampstead, MD 21074 934 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) COPD EXACERBATION Medical Due to (or as a consequence of) Examiner CORONARY ARTERY Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed VENTRICULAR FIBRIL physician and is the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Yes 2 No detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, or Attending Physician: The law requires HISTORY OF BREAST CANCER 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \( \text{\text{Nursing Home}} \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) မ ER/Outpatient 3 DOA 1 🔀 Inpatient 2 🔲 completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D44542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANTH RANGANATHAN MEYORIAL AUENUE, WESTMINSTER, MO 21157 200

Registrar

31. Date filed (Month, Day, Year)

OCT 1 3 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Etta L. Harris Dctober 75 2011 21:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours 579 30 6788 Director 91 1 □ M 2X F 07/03/1920 ŜC "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3001 Branch Ave. #228 20748 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give 1 Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Spurgeon C. Dendy Lillian James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine T.James/Daughter 5020 4th Street NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Lincoln Cem. 10/20/2011 Brentwood, MD 21. Signature of Poheral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and sthe burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Month Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 10 vas 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No after death. Accident Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Tpletely** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one) 29c. License number 29d. Date signed (Month, Day, Year, 201 10 0) 30. Name and address of person who comp ed cause of death (Item 23a) (Type, Print) erbert ton Rd Et. Washington ton VINDI 10+11

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per med cert 6921 11/16/11 dk State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34954 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0ctober Ada Chambers Hulick 2011 3 9:01 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis of Waldorf Charles Waldorf 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days \$ept. 28 Hours Min. Year **Director** 183-16-5485 94 1917 Pennsylvania Usual Residence of Deceden 28a-f show with the Maryland 10a. State 10b. County at 10c. City, Town or Location 10d Inside City Limits Director ms 23a or 28a-f s must be notified 1 ¥ Yes 2 □ No Marvland Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral P.O. Box 163 20604 USA items ? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygtene. Important: If iten 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 th. Textile Chemist vears Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 William Wilkie Chambers, Sr. Minnie Mae Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Chambers/ niece 6707 Eilerson St. Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 10/7/2011 4 ☐ Donation 5 ☐ Other (Specify) Crematory Waldorf, Marvland Signature of Tunera S, rvi Lio once, 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. ARTELIC Immediate Cause (Final nset and Death Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day signed by the at d be detached for Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been significate has pead to be a specification of the significant control of the significan 1 🗌 Yes Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? the Hospital or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) 2 No 1 Yes Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) n 24 hours after deau... ne Funeral Director: After th alated filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pleted 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one within To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) October 4, 2011 State 32 Registrar's Signature COCANO. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 449 Garrett Hansford Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) 1 X M 2 🗆 F Days Hours Yun 75. 1929 217-28-0664 Director 82 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location the Maryland **Funeral Director** 10d. Inside City Limits MD notified Allegany Rawlings 28a-f 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code must be 10g. Citizen of What Country? 23a 20640 McMullen Hwy. SW 21557 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten Examiner 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🕍 No If Yes, Give Specify. Completed 3 Widowed 4 Divorced Specify: white Vear or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) machinist Kelly Springfield Tire Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rosco Hansford Damie Everett 19a. Informant's Name/Relationship (Type, Print)
Mary Hansford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 20640 McMullen Hwy. SW Rawlings MD 21557 wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Waxler Cemetery 5 Department of Important; If any injury or once. 10/30/20 MD Rawlings 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service licenses 22. Name and carpellif Furilleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ LUNG disease or condition resulting in death) MO Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause Ent. r Inc. rlying Cause (Disease or iinjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day n signed by the a Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available has page 2 autopsy performed? prior to completion of cause of death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes <u>اء</u> this 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director; A completed filled in by the fu 2 Accident 3 Suicide 1 🗌 Yes Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗆 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P0034812 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 10 07 2011 T 10:27pm <sup>M</sup> Toia Ingram Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince george Cheverly Prince George Hospital 9. Birthplace (State or Foreign Country) pa. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 TF Months d9%18%72 **Director** 39 208-54-8259 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1X Yes 2 □ No Prince George Lanham Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20706 7937 Johnson Ave #1313 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Black 3 Widowed 4 Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Tech Support 2years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 9 Leanna Ingram Thorman Dozier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7937 Johnson Ave #1313 Lanham, Maryland 20706 f Health Nathan Jones 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o ō ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale, Md 10/21/2011 Riverdale Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Shead Tureral Tome & Cremation 077 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Malionani Cardiac Arrhythmias Medical Due to (or as a consequence of Examiner Cardiomyopathy Sequentially list conditions, Due to (or as a curvanquence of) cause. Enter Underlying and The law requires that the death certificate be executed Hypertension Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death the g 🔀 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Obesity Hypovenitilation Syndrome 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No has this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify : After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 1 Yes 2 No Investigation Accident To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after determined within 24 hours a

To the Funeral [ Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Rexford Babilah 9470 Annapolis Rd #306 Lanham, Maryland 20706

State

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year TERESA CHUSON. A M 935 3011 Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death DORCHES TER GENERAL CAMBRIDGE HOLPSTAL DORCHESTER 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) **Funeral** Months Min Days Director 52 aryland Usual Residence of Decedent "natural", or items 23a or 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified 1 Yes 2 No Dorchest 10e. Street and Number 10g. Citizen of What Country? Funeral 16/3 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Baltimore, Maryland 21215-0036  ${\not \prec}$ Armed Forces? Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Dau permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt. once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Mer Son Johnson 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ietrich Johnson ood Temple 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 0 22 4 ☐ Donation 5 ☐ Other (Specify) ethel Cemetery 22. Name and Address of Facility
Henry Funeral Hom
510 Washington 21. Signature of Funeral Service Licensee o Me, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. DISEASE CORONARY ARTERY disease or condition Medical resulting in death) Examiner DISEASE CHRONIC KIDNE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of HYPERTENSION. 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 No Other: 1 Popatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of
injury
28c. 4 Nursing Home 5 Residence 6 Other (Specify) funeral ( Certificate: 27. Manner of Dea 28c. Injury at 28d. Describe how injury occurred Natural Assistan 5 Pending work? Investigation 6 Could not be Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D69234 11 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JEENAN

ERRABOLU

BYRN

**5-3** Registrar's Signaty STREET

CAMBRIDGE

MARY LAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Ochober 2019 Saundra G. Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death Prince George's Examiner Lanham Doctors Community Hospital 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Washington, DC 1 M 2 XF 47 Sept. 6,1964 214-86-5636 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County death with the Maryland Director 3a or 28a-f sh 1 🗌 Yes 2 No Maryland Anne Arundel Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral United States 20721 839 Lakeshore Drive ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after oment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir 3altimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify Specify: Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Consulting firm Human Resource Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Hicks Robert L. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Green -mother 12525 Waldo Lane Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 N Burial 2 Cremation 3 Removal from State 10/15/2011 Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner MRS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events ransit law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Dav Year Pregnant at time of death Unknown the 8 9 Unknown this certificate has been signed by ral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Hospital or Attending Physician: The 24 hours after death. 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospira. ...
within 24 hours after death.
To the Funeral Director. After thi 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lecritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 20 29c. License number 29b. Signatur

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day,

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who completed cause of death (Item 23a) (Type, Print) 8116

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october <sup>D</sup> 4 20<sup>Y</sup> 1 1 9:38 AM Reginald Ricardo Kellibrew Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Year) 577 62 9207 62 1 X M 2 □ F Director 08/08/1949 DC Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Prince George's Upper Marlboro MD 10g. Citizen of What Country? Funeral USA 5605 S. Marwood Blvd #304 20772 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 Yes 2 1 X Yes 2 No If Yes, Give 1967-70 Year or Dates. þ 1 Never Married 2X Married Specify Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: 3 Widowed 4 Divorced "natural" Completed er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life\_DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Government 12th Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) lith and Mental H 27 is marked of r traumatic ever မ Edward Kellibrew Louise Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Hawthorne Green Cir.LaPlata, MD 20646 f Health Patricia Kellibrew/ Wife other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of ō <del>=</del> ₀ cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Department of Important: If any injury or once. MD Veterans Cem. 10/21/2011 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licer MD 20601 2294 Old Washington Rd.Waldorf, edu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentiary flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-tran and Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death Į in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? is certificate has been signed l director, page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Ai ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and Itle of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

## Baltimore, Maryland 21215-0036

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rsafte ral",	ed b	3 <b>X</b> Widowed		If Yes, Give Year or Dates			1 ☐ Yes 2 🗓 No	Specify:		Sp	ecify: WH	HITE
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thin 7 ene. than he Me	Completed by	Elementary/Sec		College (1-4 o	or 5+)	life.	DO NOT use retired) TRAINER	gg	9	Atth Pay 2011 6:51 PM  4c. County of Death Prince George's  A (Year) 917 9. Birthplace (State or Foreign Country) PA.  10d. Inside City Limits 1  Yes 2 No  10g. Citizen of What Country?  U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: WHITE  16b. Kind of Business Industry  KODAK  Maiden Surname)  CARBONA  City or Town, State, Zip Code)  MD. 20740  20c. Location - City or Town, State  RIVERDALE, MD.  REMATORIUM, P.A.  ROBALE, MD.  23d. Date of delivery Month Day Year  Deacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 X Unknown and Death 1 YEAR  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  2 No 1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  2 No 1 Yes 2 No		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2	Cremation	3 Removal from Sta	ate C	cemetery, cr	oosition (Name of ematory or other plac	ce)	Date			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnariansit	ledical	(Check 2	2 '∟ Medical Ex	aminer; On the basis of	of examinatio	n and/or inve	estigation, in my opinio	on, death occurred a	it the time, date a	and place, ar	nd due to the ca	ause(s) and manner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G921 11/14/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 21,95 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/14/201 Physician/ <u>11:3</u>5a <sup>M</sup> Jean S. Kahanov Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 5/21/24 1 □ M 2 😾 F Days Hours Min. Director 492-28-6368 Washington, DC Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director Md. Rockville Montgomery tx☐ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6121 Montrose Rd. 20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. White 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Charles Shack Clara Friedenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kahanov-Son 18424 Shady View Lane Brookeville, Md. 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 10/16/11 Adelphi, Md. 21. Signature of Funeral Servicensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel M00910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for esse gorseculence on an and Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician a detached for use as the burial. Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has 1 ☐ Yes 2 ☐ No ☐ Yes 2 👿 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a prompleted filled in by the funeral completed filled in by the function completed filled fil Natural (Month, Day, Year) work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 25 min Fort 10-14-2011 Do064871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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Rockville

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For MFD #10e, 15, 18, 20 per INF, 10/31/11; HW, MCO Registra MFD #4 per MD, 10/31/11; HW, MCO Registra MFD #4 per MD #10/11; HW, MCO Registra MFD #10/11; HW MCO Registra MFD #10/11 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2011 October 10 AM Lillian Kersh /Medical 4a. Facility Name (If not institution, give street and number):7 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia 5400 Vantage Point Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/18/1919 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Chicago, IL 92 Director 320-44-5917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a State 10b County event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director 28a-f MD Howard Columbia ( ) 10g. Citizen of What Country? 10e. Street and Number #P-7 10f. Zip Code ö 72 hours after death with 21045 United States 5400 Vantage Point Road #7 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ŏ White 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates þ Specify. 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) Public Education Piano Teacher 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <del>Marnie</del> Borenstein Reuben Nathan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5981 The Bowl, Columbia MD 21045 Barbara Miller - daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) North Riverside, 20a. Method of Disposition ILDurial 2 Cremation 3 Removal from State 10/16/2011 | Forest Park, Waldheim Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels M01163 1170 Rockville Pike Rockville MD 20852 Approximate Interval Between Onset and Death 23a. Parte Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Atrial Fibrillation /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine buria transfer law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the Ö 9 Unknown 9 ☐ Unknown ٦. β signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 10 Physiclan: The page certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SE Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number October 12, 2011 D47447 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris MD 6384 Cedar Lane Columbia MD 21044 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

Physicia Medic **Examin** Funeral **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 10 DC

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	For State Registrar Ame	end#4per	Euner										Reg. I	0.0		3	1963
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olete	Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of Business																
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17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)													111111				
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	21. Signature of Fur	neral Service L	icensee	INCO	Ton	119		22. Name	and Addre	ss of Facili	ity B <b>ri</b>	scoe- gton R	Ton	ic I	Tune	eral	
	23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	rt failure. List o Final	complic nly one	cause on ea	ch line.		Do not e				cardiac c	pr respiratory a	urrest,				imate Between and Death
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Medical Certificate:	(Check 2	Certifying Medical E Certifying	xamine	r: On the bas	is of exa	mination	and/or inve	estigation, i	n my opinio	n, death o	ccurred at	the time, date	and pla	ce, and du	e to the	cause(s) and	d manner stated.
_	29b. Signature and t			92-					9c. License		01	5	29d. [	Date signe	d (Mont	th, Day, Year	
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permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Insperment of Health and Mental Hygiene. Insperment of Health and Mental Hygiene. Insperment if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Marri 3 ☐ Widowed	ied 2 🛣Married 4 🗌 Divorced	1 Yes 2 If Yes, Give	□ No 18	142-1			Specify:	o Rican, etc.)		Black Specify:		
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permit. F Departm Importa any inju		21. Signature of Fur	neral Service Lice	nsee		2	2. Name a	nd Addres	ss of Fadudwa1	d Sage	l Fu	neral	Dir	ection, Inc
6 2 2 2 2		MCGreen Wors 7 1091 Rockville Pike, Rockville, Mary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												and 20852
			rt failure. List only	mplications that cau one cause on each		th. Do not ent	er the mod	de of dying	g, such as cardiac	or respiratory a	arrest,			Interval Between
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bit.		29a. Certifier 1	Certifying Ph	ysician: To the bes	t of my know	ledge, death	occurred a	t the time	e, date and place.	and due to the	cause(s)	and mann	er as sta	ted.
the Holin 24 Holin 24 Holin 24 Holin 24 Holin Ful	Medical	(Check 2	☐ Medical Exa	miner: On the basis	of examinatio	n and/or inves	stigation, in	my opinio	on, death occurred	at the time, date	and plac	e, and due	to the ca	ause(s) and manner stated.
P 20		29b. Signature and		1/12			290	c. License			29d. D	ate signed	l (Month,	Day, Year)
		30. Name and addre		- We				D357	91		Octo	ober	14,	
		Merlyn	ess of person who K. Vemur	y, CMD 98	or death (Iten	n zisa) (Type, I orgia	<sup>Print)</sup> <b>Aven</b> u	ie. S	Suite 227	, Silve	r Sı	oring	, Ma	ryland
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Registra	ar	UUI	18201	Steren	U A.	Mari	-							

11-08011 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Paul Eugene Lichty 34965 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Oecedent's Name (First, Middle,Last) Physician/ 2 Date of Death 3. Time of Death Month Day October 25, 2011 **Medical Examiner** Paul E Lichty 0710 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 28 Race Street Cumberland Allegany 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign CountryPA Months Davs Hours Director 1 XM 2 F 211-38-6206 63 Yrs Sep 1. 1948 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits Iltimore, MD 21215-0036

nit. Pages I and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene.

oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show ry or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Allegany MD Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Race Street 21502 USA Funeral 11. Marital Status 12. Was Oecedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White, etc. 1 Never Married 2 X Married XYes Specify: white 3 Widowed 4 Divorced of Yes. Give Year 1 Yes 2 X No specify: <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Services mail handler 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Be Ira Lichty

19a. Informant's Name/Relationship (Type, Print) Anna Pauline Vought 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lichty wife 28 Race Street Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify. 10/28/201 Hillcrest Memorial Park Cumberland MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a. Part l Tenter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiacy or respiratory arrest, shock or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Oisease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician a for use as the burial -UNPENDED **AMENDEO** Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a l be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Blunt Force Head Trauma; Chronic Obstructive Pulmonary Disease; Chronic 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been sign funeral director, page 2 should be 24a Was an 24b. Were autopsy findings available Alcoholism To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh autopsy prior to completion of cause of performed ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA 1 🗸 Yes No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Subject fell FOUND: Pending 1 Yes 2 V No 2 🗹 Accident Oct 25, 2011 0650 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 \_ Could not be Suicide or Town, State) 28 Race Street, Cumberland, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 26, 2011

Registrar
DHMH 17 Rev 1/2001

**OCME 2006** 

State

900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Russell Alexander MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fannie Elizabeth Miller 2011 <u>october</u> 5:00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Golden Living Center Carroll Westminster 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 98 **Director** 216-28-9287 9/21/1913 MD Usual Residence of Decedent 28a-f shov of Health and Mertal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Carroll MD Westminster 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1234 Washington Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify white Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) seamstress sewing factory Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carroll Austin Emma Louise Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Viola Seiler, daughter 2737 Shiloh Road, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial G. 10/17/2011 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Lice M00741 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) nu Medical Due to (or as a consequence of) Examiner roverse Sequentially fist conditions Examiner if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after o Puneral Direct 4 Homicide determined Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifie

Box 68760

P.O.

DHMH 17 Rev 7/2009

State Registrar

OL 31. Date filed (Month, Day completed cause of death (Item 23a) (To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 95 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10/12/2011 LULA MAE MARTIN 3:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Nursing & Rehab Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth Funeral Hours 1 1 M 2 X 11/21/1932 Director 220-92-4483 78 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f sl notified 1X Yes 2 No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be 23a Funeral 10518 Westlake Drive, #103 20817 ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black 3 XWidowed 4 Divorced Year or Dates Heath and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical! 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3rd Homemaker Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Doye Irene Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard J. Martin/son 12321 Walnut Point West, Hagerstown, MD 21740 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Gate of Heaven Cem. 4 Donation 5 Other (Specify) 10/24/2011 Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St. Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary artery disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Cereberovascular accident that initiated events Due to (or as a consequence of) resulting in death) Last Medical Certificate: To Be Completed by Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and templated filled in by the funeral director name?

	d								-	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	delivery Day	Year								
Part II. Other significant conditions	s cont	ributing to death but not res	sulting in the underly	ing ca	use given in Part I.		23e. Did tobacco			e of death?
							24a. Was an autopsy performed? 1  Yes 2 X N	prior death	to completic	dings available on of cause of lo
25. Was case referred to medical	1				26. Place of Death (Che	ck or	nly one)			saturation of
examiner? 1  Yes 2 <b>X</b> No	Ho	Hospital: 1  Inpatient 2  ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death  1 🔀 Natural 5 🗆 Pending 2 🗀 Accident Investigat	tion	28a. Date of injury (Month, Day, Year)	28b. Time of injury	- 1	c. Injury at work? 1 🗌 Yes 2 🗎 No	280	d. Describe how injur	y occurred		
3 Suicide 6 Could no 4 Homicide determine	office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 L Medical Exa	amine	ian: To the best of my know r: On the basis of examinatio Practioner: To the best of m	n and/or investigation	n, in m	y opinion, death occurred	at the	e time, date and place	e, and due to t	he cause(s) a	nd manner state

29c. License number

D4116

29d. Date signed (Month, Day, Year)

10/19/2011

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

G

OCT 192011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinu Ganti, MD 19529 Doctor's Drive. Germantown, MD 20874

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

**Division of Vital** 

11800 Tech ld #240

son who completed cause of death (Item 23a) (Type, Print)

Sean Dama	ascus McIntyre	
11-07879	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene	1 0100
	1- For State Registrar Certificate of Death Reg. No.	11 3496
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Pay  Ver	3. Time of Death 0055 hrs
6	Sean Damasus McIntyre October 20, 2011  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of D	
	2972 Kaverton Road Forestville Prince Geo  5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 18. Date of Birth (MM/DD/YYYY) 9	
Funeral Director	5 ( )	oreign Country)  D.C.
	Usual Residence of Decedent	
p www.	10a. State 10b. County 10c. City, Town or Location  Md Prince George District Heights	10d. Inside City Limits  1 X Yes 2 No
the Maryland a or 28a-f she tiffed at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What 0	Country?
rith the Maryland 123s or 28s-f show. 20dified at once.	7610 Kipling Parkway 20747 USA	
r death with or items 23.	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A White, et	merican Indian, Black, c.
s after d	3 Widowed 4 Divorced it res give year 1 Yes 2 X No specify: Specify: Specify:	lack
2 hours "natu	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
5-0036 lied within 72 hour Hygiene, 1 other than "natu the Medical Exam Completed	3years Justice Department Federal	Government
2121 hould be fill and Mental b is marked ric event,	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S	
b, MD and 2 short	William McIntyre Father 7610 Kipling Parkway District Heights,  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City	
nore	1 Burial 2 Cremation 3 Removal from State crematory or other place)	le,Maryland
Baltimore, oemit. Pages la Department of Her Important: If ite injury or other tr	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Home & Cremation	
Physician	0777 5732 Georgia Ave NW Washington, DC  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	20011 Approximate Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Smoke inhalation and thermal injuries	Between Onset and Death
Zamilei	or condition resulting in death)  Due to (or as a consequence of):	
Kaminer	Sequentially list conditions,  if any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying Cause	
executed an and al-transi		
68760, certificate be execunding physician and seas the burial - Trassant Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deli	/ery
Box 68760 e death certificate b the attending physi ed for use as the bu hysiclant/Mee	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month  Pregnant at time of death 5 Other (Specify)	Day Year
D. Box ( the death co by the attend sched for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute	to the course of death 2
P.O. res that signed be detay	Athorogolometic Continuouslan Dianasa 1 Yes 2 No 3 F	
ords w requi	24a. Was an 24b. Were autopsy prior	autopsy findings available to completion of cause of
Records,  The law require, ficate has been sign, page 2 should be	performed? death 1 ✓ Yes 2 No 1 ✓	
Division of Vital Records, P.O. talor Attending Physician: The law requires that the raper death.  In Director: After this critificate has been signed by ted in by the funeral director, page 2 should be detach striffication: To Be Completed by P	25. Was case referred to medical  examiner?  Hospital:	her Scene
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ision Attend r death. ector: by the f	Pending Investigation   Fd 10-20-11   Fd 12:38 am   11   Yes 2   No   No   No   No   No   No   No	D. al D. at North Cit
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 2972 Kay Forestville, Md.	
To the Ho within 24 To the Fu complete!	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (	
	O.C.M.E. October 20, 20	
	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State	31. Date filed (Month Day Year) 38 Registrar's Signature	
Registrar	OCT 28 2011 Jenus B. parls	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No. 20 | |

		1 - For State Registrar	State of Marylanc		tificate of Dea			Reg. N	Z [] [ ]	34970	
Physic		Elleen Gon		Murphy	7		2. Date of Dea 10 1 1 / 2		ay Year	3. Time of Death 1:58 A M	
Exam	dical niner	4 = 100 44 44 44 44 44 44 44 44 44 44 44 44 4		1705	4b. City, Town, or Loc Bethesda	ation of Death		40	c. County of Deat	ery	
Funera Directo		Social Security Number 6. Se			If Under 1 Year If U	Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da 11-21-	y, Year)	Cou	hplace (State or Foreign untry) V York	
Maryland 28a-f show	Finarral Director	Usual Residence of Decedent 10a. State 10b. County Florida Collier	10c. City,	Town or Loc						10d. Inside City Limits 1 □ XYes 2 □ No	
with the s 23a or ust be n	oral D	10e. Street and Number 1320 Bald Eagle	Orive		10f. Zip Code 34105				itizen of What Co ted Stat		
<b>BAITIMORE, IMATYIANG 21213-0U36</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	od by Eur	1 ☐ Never Married 2 💢 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If	las Decedent of Hispar Yes, specify Cuban, M Yes 2 🔀 No Sa	exican, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.	
Baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o my injury or other traumatic event, the Medical Exam	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give ki	ent's Usual Occupation ind of work done during NOT use retired) her	ı g most of workiı	ng		Kind of Business	•	
be filed w ental Hygi ked other	To Be	17. Father's Name (First, Middle, Last)	<del></del>		18. E1	Mother's Name	(First, Middle, enez <b>ia</b>	Maiden	Surname)		
Mary 12 should alth and Ma 27 is mar r traumati		19a. Informant's Name/Relationship (Ty) Lauren A. Northro	r Town, State, Zip	o Code)							
IMOFe, Page 1 and ment of Heg tant; If item ury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State cer	ace of Dispos metery, crem	ition (Name of atory or other place)	10-1	Oate 4-2011	20c. l Fa1	ocation - City or	h, VA	
Departit. Departimond	ouce.	21. Signature of Everal Service Litense	ee e	<sup>22.</sup> <b>51</b>	Name and Address of	Facility Jos sin Ave.	NW Was	wler shir	gton, D	C 20016	
Medica Examine punial fundament	al er e	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	Due to (or as a conseque	Diseas ence of):						Approximate Interval Between Onset and Death Years	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and appropriate in by the funeral director, page 2 should be detached for use as the burial traces.	by Physician/Medi		.3c. If yes, outcome of pregnand    Soc. If yes, outcome of pregnand   Live Birth   2	death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year	
requires that the requires that the been signed by the	eted by Pl	Part II. Other significant conditions co		_	nderlying cause given in	Part I.	1 🗆 '	Yes 2	No 3□P	the cause of death?	
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Physiciar Physiciar this certif al directo	To Be	1 ☐ Yes 2 ☐ No	Hospital:  1  Inpatient 2 E  28a. Date of injury 2	R/Outpatient	Lau		me 5 Resid		X 6 Other (Spec	2nd Reside	
DIVISION OI tal or Attending Pl rs after death. al Director: After tt ed in by the funeral	Certificate	1 Natural 5	ry occurred  and Number or Rui	ral Route Number,							
Spital or hours afte neral Dire	ical Ce	1	e) .nd manner as sta	ated.							
o the Ho vithin 24 I o the Fu	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y									
	2	Cavaed / Cul		20.10	D002660	07			ober 11.		
		30. Name and address of person who con Edward T. Cullen	MD 7625 Wiscon	nsin Av	ve. Suite 1	LO1 Betl	nesda,	MD :	20814		
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re bar	13						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:35p M Regina Medical Morgan October 0 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington
Social Security Number 6, Sex 7, Age (in vrs. last birthday) Montgomery <u>Rockville</u> **Funeral** If Under Hours Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 😾 F Min. Months (Month, Day, Yea L2/22/17 Director 048-01-2603 Connecticut Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Montgomery Rockville 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Rd. 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Samuel Weiss Mary Rose Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai once. Frank Strauss-Nephew PO Box 1210 Vail, Co. 81658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 10/14/11 Adelphi, Md. 21. Signature of Funeral Service Licensee M00910 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike Rockville, Md. Edward Sage1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Advanced Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) e burlat desi Cause (Disease or linjury Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burlat Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 No 9 Unknown Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \( \subseteq \text{Yes} \) Certificate: 28d. Describe how injury occurred 1 💆 Natural 5 Pending injury n 24 hours after death. e Funeral Director; Aft bleted filled in by the fur Investigation 6 Could not be 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 deficiency. The cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Force, Doo64871 10-11-11

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

Montrose Rd

Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazli

182011

31. Date filed (Month, Day, Year)

MD

6/21

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#10eperFH, 10/27/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10, 2011October Sophia Grace McCabe 10:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Min. April 13, 1914 New York **Director** 095-38-1127 97 1 M 2 F Yrs Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8505 Springvale Road Funeral #34 20910 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3X Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ or other traumatic event, the Homemaker Own Home  $\mathbf{B}_{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I မ Leroy Harrington Caroline Grace Goldberg 20904 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Sally Jenkins/Daughter 1017 Hollywood Avenue, Silver Spring. Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 10/17/2011 Falls Church, Virginia 22. Name and Address of Facility ward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licens mo1597 Mcgreenher 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. ici.n disease or condition Massive Rightside Stroke Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 XNo the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? 1 ☐ Yes 2 ☐ No Yes X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 **X**No Other: ပ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work 1 Yes 2 No Director: A 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide determined within 24 hours at
To the Funeral Di
Completely filled in Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) D71253 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Malik, MD 1500 Forest Glen Road, Silver Spring, Maryland 20910

State

Registrar

OCT 18 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34974 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margules October Zygmunt 10, 2011 6:05 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Bethesda Suburban Hospital 6. Sex 1 M 2 D F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 06/96./IYYIB Poland 95 059-26-2931 Director Yrs Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 ☐ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b 20814 4925 Battery Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Clothing 12 Designer n and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rachel Winter Mendel Margulis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a 2147 Royce Street Brooklyn, New York 11234 Marcia Schiff-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place injury or permit. Page Department of Important: It any injury or 10/12/2011 Flushing, NY Hebron Cemetery ky-Goldberg Memorial Chapels Address of Jacity Dan 1978 Ky 7 Rockville, MD 208 Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Dementia that initiated events Due to (or as a consequence of): resulting in death) Last ending physician ( r use as the buria<u>)</u>. Physician/Medical P,O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? certificate 1 Yes Yes 2 🔀 No Were of the Sy Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1. Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë 28c. Injury at 1 🔀 Natural 5 Pending Certificat 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ompleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 1)65312 SUDARSHAN SIVA 30 10/11/11 ddress of person who completed cause of death (Item 23a) (Type, Print)
shan Siva, MD 8600 01d Georgetown Road Bethesda, MD 20814 Sudatshan Siva, MD 31. Date filed Worth Day, Year) OCT 1 8 2011 2. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Bonnie Jean Navlor 9 2011 3:00a Medical October 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 1 M 2 TXF Hours 219-66-4570 Yrs Director 56 T.A 2/18/1954 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Carroll 1 🗆 Yes 2 🔀 No MD Hampstead 10e, Street and Number 10f. Zip Code 6 10g. Citizen of What Country? Funeral 23a 21074 USA 2824 Cape Horn Road 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc ö ģ 1 Never Married 2 X Married Yes 2 😾 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: white "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 secretary State of MD and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Phyllis Woodland William George Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2824 Cape Horn Rd., Hampstead, MD 21074 Barry P. Naylor, husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/12/2011 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Signature of Funeral Service Licenses any in 22. Name and Address of Facility Eline Funeral Home M00741 934 S. Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ METASTATIC ESOPHAGEAL CARCINOMA -2 months disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION Sexus itially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): HYPERLIPI DEMIA or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ίο Pregnant at time of death Other (specify) signed by the a d be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 N 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

WA 10

S1. Date filed (Month, Day, Year)

OCT 12

PARIYU MD

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. park

3000

D0061558

MMCHESTER

Rd, SKJ, Manchester MD 2/102

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HRLE ctober 201 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death arroll arrol pita 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1/23/1937 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 234-50-8300 74 WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Hampstead 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20012 Grave Run Road 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2**∑** No Specify white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Arthur Pennington Fannie Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frankie A. Pendleton, husband 20012 Grave Run Road, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 10/8/2011 Hampstead, MD 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service License M00741 remmer 934 S. Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ung Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mental Status eremic IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? story of melanosis coli, Biz deficiency 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? perform 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 / No 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner executed Box 68760. The law requires that the death certificate be P.O. Records, Division of Vital the Hospital or Attending Physician:

and burlal-trar the attending p as the signed by the cate has l director, this funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, In M. Model Extrining many any Injury or other traumatic event, In M. Model Extrining many.

**Physician** 

/Medical

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

To the Hospital or con-within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 12

and manner stated.

MD

32. Registrar's Signature

incom

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RANGANATHAN

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D44542

200 Memorial Avenue,

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra MEND#2+3perMD, 10/18/11; EMW, MoCo Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct. 10, 2011 Physician/ Darnelle Peerv October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Numb 8. Date of Birth
(Month, Day, Year)
July 39,1934 **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 413-48-7585 1 M 2 X F **Director** 77 Tennesse Usual Residence of Decedent fshov 10a. State the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 28a-f 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 1204 Dale Drive 23a Funeral 20910 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, ö Black, White, etc. 1 Never Married 2 Married ρ ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black "natural", ted 3 X Widowed 4 Divorced Year or Dates Medical Comple 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Teacher Special Education 4+ other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ James Macklin Phoebe Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> 1 and 2 sof Health 1204 Dale Drive, Silver Spring, MD 20910 Yvany Peery/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geo. Wash. University October 13 permit. Page 1 Department of Important: If it any injury or o ŏ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Washington, D.C. 2011 Medical Center ture of Funeral Service Licens 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): n and Urinary Tract Infection Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician a use as the burial-1 Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months? for Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, should b Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2X No မ Other: 1 X Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at After 28d. Describe how injury occurred 1 X Natural 5 Pending work? injury n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur Accident Investigation 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. petel: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I the only one) 29b. Signature and title of cer 29c. License numbe 29d. Date signed (Month, Day, Year) D67589 October 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Harold V. Lawson Silver Spring, MD 20910 M.D. 31. Date filed (Month, Day,

State

Registrar

Registrar's Signature

18 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 34978 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Year Physician/ 1900 Carl A. Pressman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Western MD Regional Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Sept 2, 1917 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 1 Hours West Virginia 94 Director 705-10-7902 Sept Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or items 23a or 28a-f sho miner must be notified at Director 1 X Yes 2 No LaVale Allegany 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21502 81 LaVale Court filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status an "natural", or iter Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married 3 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) the W MD Railroad/Chessie Chief Clerk 12 Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Idella (Weisenborn) Pressman ၉ Carl H. Pressman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12607 Henry Dr., SW, LaVale, MD 21502 Daughter Carolyn Crump 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State Oct 28,2011 LaVale, MD Restlawn Mem Gardens ! 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. Ernest 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Stage disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death ned by the a been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Mass 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 this certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 2 🛮 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 28d. Describe how injury occurred 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP-Ar R164718 10/26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 21502 12500 Willowbrook Rd., Cumberland, MD Janette Clark CRNP-AC, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rodney Allen Robinson October 2011 Medical 0750 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months 1 X M 2 🗆 F Days Min. Hours Director 218-56-1277 59 Vrs Alaska Jan 4. 1952 Usual Residence of Deceden show 10a. State with the Maryland must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Carroll 1 ☐ Yes 2 X No Westminster 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 229 Leppo Road 21158 **USA** items 2 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Vietnam Year or Dates Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian, Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Medical Respiratory Therapist is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be iment of Health and Ments Carol Robinson traumatic Emily Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 229 Leppo Road, Westminster, MD 21158 Barbara A. Robinson, wife Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grd 10/11/2011 Bel Air, MD permit. 22. Name and Address of Facility Signature of Funeral Service Licensee Myers-Durboraw Funeral Home et, Westminster, MD 21157 91 Willis Street, 127 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition no Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a d be detached for 2 No Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performed 2 🗆 No Yes 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 힏 2 (No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 5 Pending injury work? 1 ☐ Yes 2 🗌 No Accident Investigation 6 Could not be filled in by the Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Name and.

31. Date filed (Month, Day, Year,

23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Roderick Roark Re	1- For State	tate of Maryland	Departm <i>Certific</i>			Mental F		20	1 1	31,981
Physician	Registrar  1. Decedent's Name (First, Midd	ile,Last)					2. Date of Deat		1	3. Time of Death
Medical Examine		Reider					Month October 1	Day Year 5, 2011		0908 hrs
	4a. Facility Name (if not instituti 910 Sloan Avenue	on, give street and number)		4	lb. City, Town, or L Waldorf	ocation of Dea	h	4c. County of Charles	Death	
Funeral	5. Social Security Number	6. Sex 7. Age	e (In yrs. last bir	rthday)	If Under 1 Year	If Under 24H	s. 8. Date of Bir	th (MM/DD/YYYY)	9. Birth	pplace (State or
Director	194-26-9923	1XM 2F	78	Yrs.	Months Days	Hours Mi	_		Foreign	
	Usual Residence of Decedent	1 <u>6</u> 2 <u></u>	70	-				1933		· IA
any	10a. State 10b. County		10c. City, Town	n or Locati	on				T	10d. Inside City Limits
and show	Maryland Char	les		Wa	ldorf					1 Yes 2 No
or 28a-f show any fied at once.	10e. Street and Number				10f. Zip Code		11	0g. Citizen of Wha	it Count	ry?
or death with the Maryland or steep 28s-f shoust 23s or 28s-f shoust be notified at once	910 Sloan Ave				2060:			Unite		
tems st be	11. Marital Status 1 Never Married 2 N	12. Was Decedent Armed Forces?	anic Origin? ( 8 Mexican, Puert	Specify Yes or No- o Rican, etc.)	- 14. Race - White,		an Indian, Black,			
ter dez		vorced If Yes, Give Year 195	No	1	Yes 2 No	specify:		Specify:		TT
urs afte tural" smine		or Dates: 195 ecify only highest grade com	pleted) 16a.	Deceden	's Usual Occupation	on (Give kind of		16b. Kind of Bus	ness/In	White dustry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	during mo	ost of working life.	DO NOT use re	tired)			
vithin ene.		2		Disabled						
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director					Maiden Surname)					
2121 ould be fil d Mental Is s marked tic event,	Oscar Reide 19a. Informant's Name/Relation			M. Kaut	erman nber, City or Town,	State	Zin Code)			
and 2 should be filed within 7 and 2 should be filed within 7 leath and Mental Hygene.  tem 27 is marked other than reaumatic event, the Medical To Be Comple	Mark Hales/Son	, , , , , , , , , , ,	lton, MD			_p 0000,				
	20a. Method of Disposition		Date	20c. Location - 0	City or T	own, State				
TOF	1 Burial 2 T Cremation 4 Donation 5 Other S		1.0	ntory or oth sfie1	d-Echols	Charlo	tte	Hall, MD		
Baltimore, oemit. Pages I an Department of Hes Important: If iten injury or other fr	21. Signature of Funeral Service		1 2 2 2 11		ame and Address	A.E. 1911				L Home, P.A
E.E.S. O	Provil C. Echol	M0094				ry's Av	e. La Plata, MD 20646			46
Physician	23a. Part I. Enter the disease, o failure. List only one cause		the death. Do n	ot enter th	e mode of dying, s	uch as cardiac	or respiratory arre	est, shock, or hear	t	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)			ular Dise	ease				_	Death
		Due to (or as a conse	quence or):							
Jer Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):							
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outed nd nd transit	evente resulting in deathy gast	d								
iO, e be executed ysician and burial - transit	UNPENDED	AMENDED								
760 Toate I		23c. If yes, outcom	e of pregnancy			7		23d. Date of d	-	V
Box 6876( e. death certificate the attending phy dof for use as the brands.	past 12 months?	I Live Ditti	time of death	-	aldeath 3 ∟ ner <i>(Specify)</i>	_Ectopic pregr	ancy	Month	Da	ay Year
b. Box 6876 the death certificate by the attending phy ched for use as the Physician/M	1 Yes 2 No 9 Ur	known 9 Unknown		O						
Division of Vital Records, P.O. Box 6876i the Hospital or Attending Physician: The law requires that the death certificate him 24 hours fler death.  the Funeral Director: After this certificate has been signed by the attending phy upletely filled in by the funeral director, page 2 should be detached for use as the billical Certification: To Be Completed by Physician/Milical		tions contributing to death	but not resultir	ng in the u	nderlying cause giv	ven in Part I.		-	_	ne cause of death?
of Vital Records, P.O. ng Physician: The law requires that it ther this certificate has been signed by meral director, page 2 should be detach n: To Be Completed by P							1 Yes			ibly 4 🗹 Unknown
Records, The law requires ficate has been sig page 2 should be Completed							autop	sy pri	or to co	opsy findings available impletion of cause of
tal Rec	performed? death									2 No
ician: certifications rector,	25. Was case referred to medical 26. Place of Death (Check only one)  26. Place of Death (Check only one)									
of Vi g Physi ter this eral dir	1 Yes 2 No 27. Manner of Death		Scene							
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Division of ospital or Attending hours fler deat to the certal birector. After y filled in by the fune is flerification:	4 Homicide determined (Specify) or Town, State)									
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To the Ho within 24 To the Fu To the Fu complete!	one) 2 Medical Exa	miner: On the basis of exam and manner stated.	nination and/or	investigati			at the time, date a			
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	O.C.M.E. October 16, 2011									
5 DC	30. Name and address of person Jack Titus MD. De	n who complified cause of de puty Chief Medical Ex	, ,	00 W. B	altimore Stree	et, Baltimore	e, MD 21223			
State		32. Registrar		,						
Registra	111.1 21	1 7011 1 /2	A [A]	for it.	21. 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $\mathbf{P}^{\mathsf{M}}$ Caro1 Elinor Medical 8:20 2011 October 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Bedford Court Health Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
March 10,1935 **Funeral** 9. Birthplace (State or Foreign Days 1 - M 2 - F Hours of Columbia 76 Director 216-30-4186 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Formings mans to a start of the start and injury or other traumatic event, the Medical Formings mans to a start of the start of t 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Silver Spring Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14535 Kelmscot Drive 20906 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) r than " **Educational** Elementary/Seconday (0-12) College (1-4 or 5+) Institute Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stephen J. Ryan Virginia Keeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dan Maurice Ranhart (Spouse) 14535 Kelmscot Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State October 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, VA Signature of Funeral Service Lic 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. First allowards in the sequence of the seque Examine Due to (or as a consequence of) anding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 X No
9 Unknown Day Month Vear signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagn performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

10

Medical

29a. Certifier (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Doo54566

29d. Date signed (Month, Day, Year)

October 18, 2011

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Sunitha Bhogavilli, M.D., 9801 Georgia Avenue, #117, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 34982 11-07745 Philip Rozvazhevskiy State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 15, 2011 **Medical Examiner** 1730 hrs Philipp Rozvazhevskiy 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 11/12/1922 CountryUkraine 1 X M 2 F 88 218-41-3379 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mornell Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she
injury or other tranmatite event, the Medical Examiner must be notified at once Maryland Montgomery Bethesda Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4521 East West Highway, #1202 20814 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married 1 Never Married Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo Meister Eugenia Rozvazhevskaya 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6315 Rockhurst Road, Bethesda, Maryland 20817 Irene Aluker - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Memorial Grans | 10/10/2011 | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 20904 Judean Memorial Grdns| 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee <u> 11800 New Hampshire Ave., Silver Spring,MD</u> Approximate Interval **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line Between Onset and /Medical Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≛xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial - transit law requires that the death certificate be executed ca UNPENDED AMENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other ٩ ✓ Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier (Check only 1 one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal

Registra DHMH 17 Rev 1/2001

**OCME 2006** 

State

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

and manner stated

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

October 16, 2011

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0	Examir	ner	LA P	lata	Center			4b. Cit	ty, Town, or	Plata	th	1	4c. County	of Death	.5	
	Funeral Director	Г	5. Social Security N				last birthday) Yrs.	If Und Month	der 1 Year s Days	If Under 24 Hrs Hours Min		of Birth	20		lace (State	
			Usual Residence of			91	115.				13~	8-19	20	IVIA	DNAPP	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10a. State	10b. County	( -	10c. C	ity, Town or Lo	^						1	0d. Inside C	ty Limits
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小子なくも W. fital Records, P.O. Box 68760	r requires that the death certificate be been signed by the attending physic should be detached for use as the b	Physician/Medical	in the past 12 n 1 ☐ Yes 2 █ 9 ☐ Unknown	months?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic☐ Other (	pregnancy specify)	<i>'</i>		_ 1	Mor		,	⁄ear
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	edical	29a. Certifier 1 (Check 2	■ Medical Exam	sician: To the best of iner: On the basis of e	xaminatio	n and/or inves	tigation in	my opinior	death occurred	and due to th	ie cause(s)	and manne	to the cou	ca/c) and ma	nner stated,
	To the within 2 To the comple	Σ	only one 3 29b, Sighature and ti	_ Certifying Nurs	se Practioner: To the	best of m	y knowledge.	doeth-úbri	inted at It a	thre, date and pl	ics and day	to the cauca	ate signed	iner ac eta	ted	
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			State Registrar				Certificate of Death  Reg. No.  2. Date of Death  3. Time of Death									
	Physicia	ın/	Decedent's Name     TAMPO DI		*						2. Date of Dec		201 <sup>Year</sup>	3. Time of 22: 20		
	Medic Examin	cal		DOLPH SW	e street and number,	)		4b. City, Town, or	r Location o		OCTOBE		nty of Death		IVI	
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	Funeral Director		5. Social Security No. 215–38–32	216	Sex 7. A	nge (In yrs. Ias 69	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birl Month, Da NOV • 5			nplace (State of	r Foreign	
	show	۱۶	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	, Town or Loc	ation						10d. Inside Cit	ty Limits	
	Maryla 28a-f etified	rect	MD	PRINCE O	SEORGES	C.F	APITOL	HEIGHTS						1 X Yes	2 🗌 No	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Ithem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Num 5729 EAGI					10f. Zip Code 2074:	3			10g. Citizen o UNITED				
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Division of Vital Records,	al or Attend s after death I Director; d in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not I determined	28e. Place of I	njury - At hon etc. (Specify)	ne, farm, stre	, farm, street, factory, office  28f. Location (Street and Nun City or Town, State)						al Route Numb	oer,	
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death.  To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical		Medical Exam	dge, death occured at the time, date and place, and due to the cause(s) and manr and/or investigation, in my opinion, death occurred at the time, date and place, and du knowledge, death occurred at the time, date and place, and due to the cause(s) and m						due to the c	ause(s) and ma	nner stated.			
	No the vith com		29b. Signature and	title of dertifier	A			29c, License number 29d, Date signed (Mon						Day, Year)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 08 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eddie Mac Shorter October 2011 Medical 11:35A M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice of St. Mary's Callaway st. Mary' Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**火** M 2 □ F Days Hours (Month, Day, Month Director Country) 215 46 4981 64 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 K Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20002 1615 Lang Place N.E. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes If Yes, Give 2 🗆 No 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 1966-68 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th National Airport <u>Parking Supervisor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Howard Shorter Geneva L. Gough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Wedge/ Sister 46438 Sue Dr. Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Evergreen Mem.Cem. 10/22/11 Great Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on, ach line. or complications that caused the death. Do not ent the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final ∉nysician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physician Physician/Medical Box 68760 After this certificate has been signed by the attending I funeral director, page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 No 은 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accide 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schmidt, Jennifer MD 40900 Merchants Lane Leonardtown, 20650 MD

Registrar

State

Day, Year) 19 2011

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show any natic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		12. Was De	cedent Eve	r in U.S.	13. Was			igin? ( Spe	ecify Yes or No				can Indian, Black,
death or iten	nue	1 X Never Marri	ed 2 M	arried Armed	Forces?	No	If Yes	s, specify Cub	an, Mexican	n, Puerto I	Rican, etc.)		White,		,
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5-00 led will tygien other	Con	17. Father's Name	(First, Middle,	Last)			-		18.Mother	r's Name (	First, Middle, I	Maiden		way	
21215-0036 21215-0036 ould be filed within 7   Mental Hygiene, marked other than ic event, the Medica	Be			m Bucanhen						Fr1i	ne Dean				
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Balt permit Depart Impor injury		basec	0	milm	333				Lee	Funeral	Home	e,Inc 66	533 (	Old Alexandria	
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i, P.O. Box 68 lires that the death certif signed by the attending be detached for use as	by P	Part II. Other signifi	icant condition	ons contributing to	death but r	not resulting	in the und	erlying cause	given in Par	rt I.	23e. Did to	bacco	use contribu	te to th	e cause of death?
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death.  at Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach	음	1 ✓ Yes 2 27. Manner of Death		28a. Date	npatient 2 of Injury		patient 3		Other <sub>4</sub>		Home 5 F		nce 6 🗸 (	Other: 8	Scene
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 C	ertifying Phy	sician: To the bes	t of my know	vledge, deat	h occurred	at the time, o	late and plac	ce, and du	ue to the cause	e(s) and	d manner as	stated	
To th within To th	Medical	one) 2		iner:On the basis of and manner s	of examination tated.	on and/or inv	estigation,			curred at the	ne time, date a				
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Sta		31. Date filed (Month	Day, Year)	32. Ré		er 900 W. Baltimore Street, Baltimore, MD 21223 ar's Signature									
Regist	ar	U	01 18	2011 /2	recons										

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 21,02 Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Month Edith Rae Simon 6:30 P.M October 2011 Medical 14. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 579-38-5744 **Director** 1 🗆 M 2 🗶 F 87 12/13/1923 North Carolina Usual Residence of Deceden 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director Maryland Prince George's 1 Yes 2 XNo Brandywine 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 8321 Cedarville Road 23a 20613 U. S. A. items 2 Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Prince George's County other than Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever 2 0. Worth Barnes Mabel Irene Renfrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Harland Dale Simon II/Son 35192 South Drive, Lewes, Delaware 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 10/16/2011 4 $\square$ Donation 5 $\square$ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home de P. Kri mo1164 3035 Old Washington Road, Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final h sician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death ed by the ar Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforn death? this certificate 1 Yes 2 No Yes or Attending Physician: funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 🗌 ER/Outpatient 3 DOA s after deam. al Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

To the Hospital within 24 hours a filled in by

Medical

29a. Certifier (Check

29b. Signature and title of certifie

determined

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 06-2011 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to

Registrar's Signature

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28f. Location (Street and Number or Rural Route Number,

the cause(s) and manner as stated.

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:42 am Israel Lewis Schneider 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 09/17/1924 1 🗶 M 2 🗆 F Months Days Hours Min 87 **Director** 149-14-8231 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🕱 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20910 U.S.A. 2445 Lyttonsville Road. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? 1 ☑ Yes 2 ☐ No Army 5 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", WWII 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Private Industry Engineer 5+ alth and Mental Hygie 127 is marked other or traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Helen Schoenwald Jacob Schneider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 2445 Lyttonsville Rd., #617, Silver Spring, MD 20910 Alice Grove Schneider - Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns: 10/18/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signatur 1800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Pulmovary disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Exami attending physician and for use as the burial-transit Due to (or as a consequence of): 15, FO. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death sate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by arterdisase 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an autopsy Alsove this certificate filled in by the funeral director, 25. Was case re 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at e Hospital or Attending Pr n 24 hours after death. e Funeral Director: After th Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 2 🗌 No Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature applittle of certific 29c. License number D23019 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOUIS KOZLOGG ND 8218 WISCONSIN AUS; BETHESDA, ND 20814 31. Date filed (Month, Day, Year, 2. Registrar's Signature State 1 9 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:28 PM Jerune Schuen Fe Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 931 Edgewood Road #313 Annapolis Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Hours 0472371923 097-18-5775 **Director** 1 🛛 M 2 🗆 F Yrs 88 Usual Residence of Deced show 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 United States 931 Edgewood Road #313 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces þ 1 Never Married 2 Married 2 No Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 ☐ Divorced WW TT Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Data Processing Manager traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, and Mental F ္ဝ Amelia Schwam Adolph Schoenfeld it. Page 1 and 2 should be irtment of Health and Men irtant: If item 27 is marke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1806 River Watch Lane Annapolis MD 21401 Richard Schoenfeld - son other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State njury or 10/7/2011 Farmingdale, NY 4 Donation 5 Other (Specify Ararat Cemetery Danzansky - Goldberg Memorial Chapels Inc M011631170 Rockville Pike ROckville MD 20852 23a. Part inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CUrchary TENS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Parkinson Sequentially list conditions, if any, reading to infinite cause. Enter Underlying Examine burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the 88 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 1 Yes 2 No After this certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Work? 1 ☐ Yes 2 ☐ No Investigation Could not be after death Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Prijacian To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 051819 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 132 Huliday Malta 67 1.

State Registrar 31. Date filed (Month, Day, Year)

/32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2011 Edward Lee Simpson 5:54A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 4/29/1916 Days **Director** 246 05 4513 1 🔀 M 2 🗆 F 95 NC Usual Residence of Decedent show 10d. Inside City Limits 10a. State with the Maryland ms 23a or 28a-f shore must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD Prince George Hills <u>Temple</u> 10e, Street and Number 10g. Citizen of What Country? Funeral 5202 Redd Lane 20748 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Armed Forces?

1 Xyes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc., ò þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 6 th College (1-4 or 5+) ţ Driver <u>Private</u> of Health and Mental Hygi item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Issac Simpson Nora Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other trau Josephine Jackson/Daughter 2423 Porter Ave. Suitland, MD20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cem. 10/17/2011 Winston Salem, NC 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee Camberen 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sylock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mudo disease or condition Medical resulting in death) Due to ( as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami burial-transi Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s has this certificate 1 Yes 2 No I or Attending Physician: after death.
Director: After this certifications funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNO 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No filled in by the Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-greto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 844 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4.16 P. M 2. Date of Death Physician/ CIONOR DAVID ANDREW SLAUGHTER Medical 44. Facility Name (if not institution, give street and number **Examiner** City, Town ocation of Death County of Death If Under 2 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Hours DFCFMBFR 31 VÍRGÍNIA Director 224-28-1720 87 1923 Usual Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f st notified a 1 ¥ Yes 2 □ No MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral UNITED STATES 11195 BEL AIRE COURT 20603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?
1 X Yes 2 0 1 Never Married 2 Married Completed by 2 □ No 1943-1 Yes 2 No Specify Specify: BLACK 3 X Widowed 4 □ Divorced 1946 Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 9TH GRADE LANDSCAPE GARDNER FEDERAL GOVERNMENT Be be filed 17. Father's Name (First, Middle, Last) aryland 18. Mother's Name (First, Middle, Maiden Surname) 2 MATTIE DAVIS SLAUGHTER JULIAN SLAUGHTER should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Health a Page 1 and 2 11195 BEL AIRE COURT, WALDORF, MARYLAND DEBORAH S. CARTER / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) QUANTICO NATIONAL CEMETERY OCT. 14, 2011 TRIANGLE, VIRGINIA 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIA LYPIA C. THORNION JOHNSON MO0583 HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PUL MONARY disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** FAILHRE DUCESTIVE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ORONAK and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Ros Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes Natural 2 🗆 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-06-2011 636 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33341 RICIA EBEN mn TA 31. Date filed (Month, Day, Year) Registrar's Signatur State UCIUY 2011 Registra

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M				and Mental Hy	/giene	1 1 1	21.0	003	
			Registrar  1. Decedent's Name (First, Middle	( act)	C	ertificate of L	Jeath	2. Date of D	Reg. No.	<i>J</i> 1 1	J 4} .		
	Physicia Medic		Katherine Mae	Stewart				0ctobe		01 <sup>Year</sup>	3. Time of 3:09	рм	
	Examir	ner	4a. Facility Name (if not institution, Holy Cross Hosp!	-		4b. City, Town, or Silver				ty of Death tgomer	у		
	Funeral Director		5. Social Security Number 287–46–2389	6. Sex 1 \( \text{M} \) 2 \( \begin{array}{ c c c c c c c c c c c c c c c c c c c	ge (In yrs. last birthda) 65 Yrs.	Months Days	If Under 2 Hours	Min. 8. Date of Bi	irth 19, Year) 1, 1946	9. Birthp Count	lace (State c	or Foreign	
	d How	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	ocation				1	0d. Inside Ci	ity Limits	
	larylan 3a-f sh ified a	Funeral Director		gomery	Silver							2 <b>X</b> No	
	a or 28	Dir	10e. Street and Number	800-7		10f. Zip Code			10g. Citizen of	What Coun	try?		
	nust	ner	2413 Darrow S	treet		209			USA				
21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 ☑ Never Married 2 ☐ Marrial 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	Ever in U.S. 18	l. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		in? (Specify Yes or No , Puerto Rican, etc.)	14. Ra Bla Specif	ace - Americ ack, White, e Whit fy:			
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land	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, L Russell L. S	<sup>ast)</sup> tewart				er's Name <i>(First, Middle</i> ty Burrall	Name (First, Middle, Maiden Surname) Burrall				
Maryland	age 1 and 2 should be file int of Health and Mental H t; If item 27 is marked o / or other traumatic eve		19a. Informant's Name/Relationsh Nancy L. Stew	nip <i>(Type, Print)</i> art/Sister	r or Rural Route Numb	pring, M	State, Zip C D 209	02					
Baltimore,	Page 1 and ment of Heal ant; If item 3 ury or other		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (S			position (Name of ematory or other place itan Crema		Oct. 16,	20c. Location				
Baltii	permit. Page Department of Important; If any injury or once,		21. Signature of Funeral Service L			22. Name and Addre	ss of Facility	ins Funera	1 Home	Inc.		.0901	
		П	23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death. Do not e					Approxima Interval Bet	te		
may.	Physician/		Immediate Cause (Final disease or condition	Acute Re	espiratory	Failure		Onset and					
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0	be executed sician and burial-transi	icalE	resulting in death) Last	d.	a consequence oi).								
876	tificate ng phy	Med	IF FEMALE:										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			Date of deliventh	-	Year	
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ion	eath. or: Aft	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation		M 1 🗆	Yes 2						
ivis)	or At after c Direct		4 Homicide determ	ined 28e. Place of In	jury - At home, farm, s tc. (Specify)	street, factory, office			(Street and Num own, State)	ber or Rural	Route Num	ber,	
	To the Hospital or Attending Physician: within 24 hours after dead or the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination and/or inv	estigation, in my opinie	on, death oc	curred at the time, date	and place, and d	due to the car	use(s) and ma	anner stated	
	To the within to the comp	2	29b. Signature and title of certifier	-1-	, coat or my randmodg.	29c. Licens	e number		29d. Date sign	ed (Month, I	Day, Year)		
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					death (Item 23a) (Type O Forest C	len Road,	Silve	er Spring,	MD 2091	10			
	Stat Registra	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satyam Shah, MD 1500 Forest Glen Road, Silver Spring, MD 20910  31. Date filed (Month, Day, Year)  OCT 18 2011  32. Registrar's Signature										

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep.	artment of Health and N		20!!	34994
			Registrar  1. Decedent's Name (First, Middle, Last)	tincate of Death	2. Date of Death	J. No,← ∪ 1 1	3. Time of Death
	Physicia		Jennie Damsky Senzel		Month	Day Year 14, 2011	10:11 P M_
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	OCLOBEL	4c. County of Death	1.10.11
أحوريا	<i>y</i>	•	Village of Rockville	Rockville		Montgo	merv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
	Director		082-12-2100 1 □ M 2 🗓 F 93 Yrs.		August 6,	1918 New	York
	nd now at	١	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation		11	Od. Inside City Limits
	arylar a-f sl fied	Director					1 X Yes 2 □ No
	or 28	<u>ا</u> قّٰۃً ا	MD Montgomery Chevy Cl	10f. Zip Code	100	. Citizen of What Coun	try?
	with t	eral	8100 Connecticut Avenue #1621	20815		USA	
	tems er mu	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - America	
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Ö	turs a	Completed	3 ★ Widowed 4 □ Divorced Year or Dates.				hite
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Baltimore, Maryland 21215-0036	should be filed who and Mental Hyge is marked other iranmatic event.		19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rura	Route Number, Ci	ty or Town, State, Zip C	ode)
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<u>=</u>	t. Page rtment o rtant: If rjury or			vid Mem. Grds 10/1 2.Name and Addres . Waamyd Sa			
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2.Name and Address of Weedillay 0. 58 091 Rockville PIke			
			23a, Part 1. Enter the disease, or complications that caused the death. Do not ent				Approximate
-40	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	e Heart Fai	lure	13	Interval Between Onset and Death
	Medical		Due to (or as a con equince of):				
	Examiner	_	Sequentially list conditions, b.	sion			
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gox	death	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
л. Э	at the		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part 1	22a Did tabas	co use contribute to th	e cause of death?
7.	law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burite mais	d by	Chronic Widney Disease	indentying dadde given in raise.		2 No 3 Prob	
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Z Z	/sicia s cert direct	To B	examiner? 1  Yes 2 No  Hospital: 1  Inpatient 2  ER/Outpatien	Other:		ce 6 Other (Specify)	
or Vital Records,	ig Ph		27. Manner eath 28a. Date of injury 28b. Time of		28d. Describe how		
0	endin eath. or: Aff he fur	fica	1   atural 5   Pending (Month, Day, Year) injury 2   Accident Investigation 3   Suicide 6   Could not be	M 1 ☐ Yes 2 ☐ No			
DIVISION	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
5	= T :		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	d due to the cause(	(s) and manner as state	d.
	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investorily one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and p	place, and due to the cau	ise(s) and manner stated.
	With a series		29b. Signature and title of certifier  MD	29c. License number		I. Date signed (Month, I	
	20			D0064624		10-15-2	011
			30. Name and address of person who completed cause of death (Item 23a) (Type, F. SANDEEL SHARMA 743 SUMME 31. Date filed (Month, Day, Year)  OCT 18 2011  C. Registrar's Signature	Print) Walle Pr.	Guithers	burg, MI	20878
	Stat Registra	•	31. Date filed (Month, Day, Year)  OCT 18 2011	ped.			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		,	For State	State of M	1arylan		artment of H		and M	lental Hyg	giene	0.1		210	05	
			Registrar	( cot)		Cer	tificate of L	Death_			Reg. No. /	Ui		545	90	
	Physicia	n/	<ol> <li>Decedent's Name (First, Middle,</li> <li>Joseph R. Stone</li> </ol>	,						2. Date of Dea Month	Day	Yea	ar	3. Time of D	eath M	
نيسر	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, or	r Location	of Death	10		inty of D	eath	7	7-	
	Exami		Carroll Hospita	1 Center			Westmins					rrol				
	Funeral	Г		ma		st birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth			Birthpl Count	ace (State or F	-o <i>reig</i> n	
	Director		Usual Residence of Decedent	73	33	Yrs.				10/10/	1928			<sup>y</sup> PA		
	and show	ē	10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside City	Limits	
	Maryl 28a-f otifie	Director	MD Baltim	ore	Wind	dsor M	ill						$\perp$	1 🗌 Yes 2	! [XNo	
	h the		10e. Street and Number				10f. Zip Code				10g. Citizen	of What	Count	ry?		
	ith wit	Funeral	2918 Ridge Road	I 40 Miss David Late	F 11.0	140.1	212		inia? (Can	nif. Vac or No	or No- 14. Race - American					
10	or dea	by Fu	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces d 1 X Yes 2	7	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						Race - A Black, W				
036	rs afte iral", Exan	ed b	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates.	™ WWI	I 1	∣ ☐ Yes 2 🔀 No	Specify:			Specify: White					
2-0	2 hou "natu adical	Completed	15. Decedent (Specify only highest			(Give	dent's Usual Occup		t of workin	ng	16b. Kind of Business Indus					
121	ithin 7 ene. • than	Som	Elementary/Seconday (0-12)	College (1-4 or	5+)		O NOT use retired) <b>libraria</b>	n		SSA						
d 2	led w I Hygi other ent, t	Be	17. Father's Name (First, Middle, La.	st)		cape	<u> </u>		er's Name	(First, Middle, I	iddle, Maiden Surname)					
/lan	d be fi	임	Zigmund Stone					Mari	ion R	ochinsk	· · · · · · · · · · · · · · · · · · ·					
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Joseph Stone/son	(Type, Print)			ng Address (Street a				per, City or Town, State, Zip Code)			ode)		
Baltimore,	of Hea of Hea if item r othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐ Removed from State	20b. P	lace of Dispo emetery, cren	of Disposition (Name of Date 20c. Location by, crematory or other place)							- City or Town, State		
ij	: Page tment tant: I jury o		4 Donation 5 Other (Sp.	ecify)		rison I	Torest Ve		•							
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice  Mark Dut	ensee			Name and Address Name and Address Name								I,PA	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List on										Approximate Interval Between			
1	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	d			RPIAL	LINFARCTION						Onset and De	a.iii	
	Examiner			Due to (or as	a consequ	ence of):	):						ŀ			
П		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):	of):						+			
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c									$\perp$			
	death certificate be executed ne attending physician and ed for use as the burial-transit	al E	resulting in death) Last	Due to (or as	a consequ	ence of):										
260	cate by physic the b	edical		d									土			
189	ath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d.	Date of	delive	rv		
30X	e atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant			Ectopic pregnand Other (specify)	У				Month		Day Yea	ar	
P.O. Box 687	es that the des signed by the s be detached t	Physician/Me	9 Unknown	9 Unknown		ulaine e les als e un		ion in Dort		00 8111		1 . 21 1			450	
σ.	The law requires that the rate has been signed by the page 2 should be detach	d by	Part II. Other significant condition					en in Part	I.					e cause of dea ably 4 🗌 Ur		
ğ	require been sig should t	letec	SCUTE KID	NEY IN	154	RY				24a. Was a	-			sy findings ava		
ecc	sician: The law certificate has l irector, page 2 s	Completed by	-	MELLITU		TYPE	L			autop: perfor	sy med?	prior death	to con	npletion of cau	ise of	
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Ĭ	Physician: 7 r this certifica ral director, p	To B	examiner? 1  Yes 2  No	Hospital:	t 3 DOA Othe	er: 4 🗆 Nu	ursing Hor	me 5 🗆 Reside	ence 6 🗆 C	Other (S)	pecify)					
o l	ding Pł h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	28b. Time of injury	28c. Injury work	?		8d. Describe ho	ow injury occ	urred					
Sior	ttend death stor: / / the f	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	t be	no farm etre		Yes 2		Of Location (St	troot and Nu	mboror	Puml.	Poute Number	,		
Division of Vital Records,	pital or Atten ours after deat eral Director: filled in by the		4 ∐ Homicide determine	building, et		e, farm, street, factory, office  28f. Location (Street and Number or Rural Route Num City or Town, State)					Todie Warnber	1				
		29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, only one)								courred at the time, date and place, and due to the cause(s) and mann				ıer stated.		
	To the Hos within 24 h To the Fun completed	29b. Signature and title of certifier 29c. License n							c. License number 29d. Date signed (Month, Day, Year)							
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,	1.,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FRANCIS KHOO, MD 200 m5moklAL AVEN							ENU	E WES	THINS	STEF	2, N	10 211	5/	
	V Stat	e	31. Date filed (Month, Day, Year)	32 Aegistr	ar's Signato											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 26,27 per dr.,g921,11/02/2011dbb
Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gerald Lamar Smith October 2011 4:53 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 13559 Pulaski Drive Hagerstown Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Hours Apr 6, 1935 Virginia 217-32-6985 76 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Hagerstown 10d. Inside City Limits 10a. State 10b. County Director Maryland Washington 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21742 13559 Pulaski Drive Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 \sum No 1954ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced 1976 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) United States Army Logistics Engineer event, permit. Page 1 and 2 should be filed a Department of Health and Mental Hyg Important: If item 27 is marked othwany injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Stella Catherine Staub Smith Kenneth Earl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13559 Pulaski Drive, Hagerstown, Mary Land 21742 19a. Informant's Name/Relationship (Type, Print) Mrs. Geraldine Sue Smith, Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory | Oct 19,2011 Smithsburg, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Keeney & Basiford P.A. Funeral Home MO1612 106 East Church St, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ no certino ma disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Yes 2 No been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has performe this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No Investigation
6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Date filed (Month, Dav. Year)

NOV 0 2 2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHRANAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:30AM Bessie Faye Thompson OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Annapolis <u>Anne Arundel Medical Center</u> If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F March 18, 1928 Pennsylvania 83 **Director** 578-38-7484 Usual Residence of Decedent tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 □ No Marvland Anne Arundel
10e. Street and Number Pasadena 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 907 Marthas Vineyard Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Maryland College (1-4 or 5+) Elementary/Seconday (0-12) Secretary State Government 12th. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked of Adeline Mahalia Gamble မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. David Franklin Green other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 907 Marthas Vineyard Lane, Pasadena, MD. 21122 <u>Phyllis A. Koenig/</u> Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Trinity Mem. Gardens Oct. 19, 2011 Waldorf, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of FA Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 MOU9D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Infarction Myocardial disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month 4 Pregnant at time of death
9 Unknown ed by the a detached f 1 Yes 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown Dementia Pulmonary Embolism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KER/Outpatient 3 IDOA မ 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ctober 15, 2011 D5753 m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millersville, 86 01 Veterans Negi nohit oct, Day, Year) 31. Date filed (Month 32. Registrar's Signature State 21 2011

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Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 09:07 AM ASEY R TOWERS 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month 1 M 2 Florida Director Oct. 216 27 5944 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland **Funeral Director** ams 23a or 28a-f sh r must be notified a 1 🗆 Yes 2 🙀 No Maryland Charles Waldorf 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 3825 Kearnys Inn Place 20602 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 Y No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Student Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Charles David Towers Barbara Ann Havs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Towers (mother) 3825 Kearnys Inn Place, Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State emetery, crematory or other place, Trinity Memorial Gardens 10/20/2011 Waldorf, MD Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6033 Old Alexandria 1101555 Sign Yure of Funeral Service License Ferry Road, Clinton, MD 20735 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARTUM hysician/ POST CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-tran and Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VENOUS THROMBOSIS 1 Tes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should CARDIAC TRANSPLANTATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an autopsy performed' I or Attending Physician: after death.
Director: After this certific 26. Place of Death (Check only one) 25. Was case referred to medica filled in by the funeral director, Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature 1215236773 3/2011

Registrar

DHMH 17 Rev 7/2009

State

HAZEL

31. Date filed (Month Day Year)

ank

22

Registrar's Signature

energy.

S. GREENEST BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WERLHOF

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar q q q Certificate of Death Reg. No. Time of DA M 2. Date of Death . Decedent's Name (First, Middle, Last) Month (O Day (1 Physician/ Fannie J Wilson Medical 4b. City, Town, or Location of Death 4c. County of Death a. Facility Name (if not institution, give street and number, **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. (Month, Day, 0 / 23 / Months Days Hours VA 1 M 2 XF 231 74 5805 58 1952 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State 10b. County ä the Maryland Director other traumatic event, the Medical Examiner must be notified 1X Yes 2 No MD Prince George' Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe items 23a Funeral with 10005 Campus Way South 20774 USA death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or ģ 1 X Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Government Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ever 2 Levinia Fulcher Leslie Wilson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 42 Sandy Point, VA 22577 JOyce Jones/ Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Zion Chu. Cemetery 10/15/201 Kinsale, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Weldon-Fisher Funeral Home f Fune al Se por Licensee Eller 22883 Kings Hwy. Warsaw, VA 22572 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TESPICATOR Ph, i ian/ disease or condition Medical resulting in death) Due to (or as a conseque ce of): Examiner MPTRSTE Sequentially list conditions, Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami requires that the death certificate be executed and -trans Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð page 2 should be 1 Yes 2 No 3 Probably 4 Uknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has performe 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Inpatient 2 ER/Outpatient 3 DOA ပ္ hours after death. uneral Director: After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 1 Natural 2 Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours Medical 1 X ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check within 2 29c. License number re and title of certifie 30. Name and address of person who completed cause of death (Item 23a) Type, Print) WETZ 7252 31. Date filed (Month, Day, Year) State OCT 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 5:15A Physician/ 2011 George Philip Wood Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital CLinton 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 67 1 🗶 M 2 🗆 F **Director** 216 42 2895 8/6/1944 MD Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location at 10a. State 10b. County Director Examiner must be notified 1 Yes 2 No Prince George's Clinton MD 10f. Zip Code 10g. Citizen of What Country? 6 10e. Street and Number 23a Funeral 20735 USA 6511 Killarney Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 1. Marital Status Armed Forces? Black, White, etc. þ "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates, 1966-71 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Freight Conductor 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margaret Williams Thomas Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6511 Killarney St. Clinton, MD 20735 Carrie M.Wood/ Wife 1 and 2 s of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State - L permit. Page Department of Important: If any injury or once. Cheltenham, MD 10/21/2011 Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee 2294 Old Washington Rd. Waldorf, MD20601 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure Inset and Death Immediate Cause (Final ₽h, sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the ar 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has perform 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 🛣 No 1 Impatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Hospital or Attending 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print 32. Registrar's Signature State 1,0 OCT

Registrar